

PSYCHOLOGY TEACHERS UPDATE

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PSYCHOLOGY OF AGEING
AND OLDER ADULTS

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PSYCHOLOGY TEACHERS UPDATE

Psychology Teachers Update is designed to give a brief overview of the main developments in the different areas of psychology. There is a proliferation of journals and research, and it is very difficult to keep abreast of the latest trends, particularly in the many and varied areas of psychology.

Each issue of Psychology Teachers Update will cover a particular topic, and summarise the main research directions and findings in the last ten to fifteen years approximately. The aim is to give teachers the feel of what is happening in that area of psychology.

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Introduction

The number of adults over the age of 65 years old is increasing in the West. For example, in 1900 in the US, it was 4.1% of the population (with 0.1% of the total population being 85 years or older). By 2000, the figures were 12.8% and 1.6% respectively (Sadock and Sadock 2003).

In 2003, the UK population was 59.5 million with 16% being over sixty-five, and about 2% over eighty-five years old (Office for National Statistics 2005) (table 1).

	NUMBER OF PEOPLE	PERCENTAGE OF TOTAL POPULATION
Total UK	59 554 000	
65-74 yrs	5 005 000	9.71
75-84 yrs	3 401 000	5.71
85 yrs+	1 104 000	1.85
65 yrs+	9 510 000	15.97

(After Office for National Statistics 2005)

Table 1 - Population over 65 years old in 2003 in the UK.

People are living longer in the West. Life expectancy in the UK at birth was 76 in 2004 up from 69 in 1950 (Gelder et al 2006).

Developmental psychology tends to divide the lifespan into clear age periods. In childhood, these may be more obvious, but, in adulthood, the division of later adulthood, ageing, or senescence is far from clear. It is in many ways, an arbitrary cut-off point.

Bradley (1996) went further:

..(C)hronological age has in itself no intrinsic significance; it only gains meaning for the behaviour characteristics imputed to it, so that the idea of a person "being elderly" or "being adolescent" triggers off certain expectations about how that person will act, feel and think" (p146).

The study of the psychology of ageing is sometimes called "psychogerontology" (Ruth 1996). Researchers in this field want to emphasise the positive aspects of later life: "a time for celebrating and for being 'in life'" (Coleman and O'Hanlon 2004).

The concept of a "fourth age" is often used for much older adults when issues of disability and frailty

dominate (Coleman and O'Hanlon 2004). This is seen also in the distinction between "young-old" and "old-old".

It means that different terms are used in relation to ageing in the textbooks. Table 2 gives some examples of the terms used (Stuart-Hamilton 2000a).

TERM	DEFINITION
universal ageing	features common to all elderly
probabilistic ageing	features that could happen, but not universal
primary ageing	age changes to body
secondary ageing	age changes which usually occur
tertiary ageing	physical decline just before death
chronological age	age since birth
social age	social expectations related to chronological age
threshold age	age of onset of senescence (eg: retirement age)
senescence	later life
third age	independent old age
fourth age	dependent old age
biological ageing	body's state of physical degeneration
psychological age	age individual feels
functional age	what individual is able to do relative to chronological age
successful ageing	adjusting to losses of ability in later life
differential ageing	individual experience of ageing
young-old	60-69 yrs
middle-aged old	70-79 yrs
old-old	80-89 yrs
very old-old/oldest old	90 yrs +

Table 2 - Terms used to describe later life.

EXPERIENCE OF AGEING

There are physical changes that occur with ageing, but none as universal as puberty. Among those individuals over sixty year old exists an incredible diversity from the marathon-running centurion (1) to the chronically ill sixty-year old, and all variations inbetween.

The study of ageing is thus a difficult area in which to generalise, yet it exists within the shadow of the stereotypes of inevitable decline. The biggest challenge for psychology here is to highlight the difference between fact and stereotype:

At best, they may be regarded as physically vulnerable and in need of protection. At worst, they are seen as "past it" and a subject of mockery. Indeed, one of the prime features of ageist humour is the concept of an older person behaving in a manner considered more appropriate for a younger adult (eg: .."mutton dressed as lamb")
(Stuart-Hamilton 1997 p20).

The presence of more older adults in the West means diversity, and recognising the "heterogeneous nature of ageing" (Biggs and Daatland 2006). Thus we need to talk about "multiple pathways" to ageing, and the challenging of common assumptions and stereotypes. The term "differential ageing" is also used to highlight the individualised process of getting old (Smith and Gerstorf 2006).

Smith and Gerstorf (2006) proposed a set of criteria by which to assess "differential ageing":

- Status (of individual): high, average, low;
- Quality (of experience): successful, desirable, robust, resilient;
- Direction (of change): increase, maintenance, decline;
- Rate (of change): fast, slow, fluctuating;
- Timing (of change): early, late, event-related;
- Individual differences in longevity.

Table 3 applies these criteria to two different individuals in the US - a rich White male, and a poor Hispanic female (both aged seventy years old). The experience of ageing will be very different for each individual.

The Berlin Study of Aging (BASE) (2) created nine psychological profiles for the experience of ageing in their sample (n = 516) - four of the profiles were positive ("successful ageing"), and five were negative

(Smith and Baltes 1997) (table 4).

	RICH WHITE MALE	POOR HISPANIC FEMALE
Status	high - wealth allows greater choice/freedom	low - limited choices
Quality	successful - positive experience of eg: leisure	resilient - continued struggle to survive
Direction	maintenance - physical changes overcome by buying treatments	decline - health affected by life struggles
Rate	slow - decline in health	fast - decline in health
Timing	late - longer life expectancy	early - shorter life expectancy
Overall	enjoyment of long period of retirement	continued struggle to survive with failing health

Table 3 - Experiences of "differential ageing" for two individuals in the US.

	% OF SAMPLE	AVERAGE AGE (years)
POSITIVE EXPERIENCE		
Cognitively very fit, vitally involved	9.8	77.9
Socially oriented and engaged	5.7	82.5
Cognitively fit, well-balanced easing through life	23.3	81.1
Cognitively fit, reserved loner	8.2	81.1
NEGATIVE EXPERIENCE		
Fearful, lonely but supported	14.7	88.0
Anxious, lonely, holding on to control	8.6	84.7
Dependent, but well-balanced	12.5	91.2
Cognitively impaired, disengaged but content	10.7	88.5
Cognitively impaired, withdrawn, in despair	6.2	91.2
Uncategorised	0.3	

(After Smith and Gerstorf 2006)

Table 4 - Nine psychological profiles of ageing from BASE.

The authors concluded from the research findings:

The outcome is clear. Risk of membership in the less desirable clusters was larger for the oldest old compared with the youngest old. The oldest old, and especially older women, are at a much higher risk for dysfunctionality than the young old (Smith and Gerstorf 2006 p23).

One way of viewing older adults is in terms of "functional age" (Wood et al 2002). The focus is upon what the individual can do rather than their chronological or biological age.

The experience of ageing is also influenced by gender, social class, and ethnic differences. For example, older white males often struggle with a loss of power on retirement from work (Stuart-Hamilton 1997).

Arber (2006), taking a "feminist political economy perspective", has argued that older women have a disadvantageous position in relation to older men, and particularly in terms of income. For example, from British official statistics, women over 65 years were significantly more likely to be in the lowest income groups than men over sixty-five, and widowed women are most likely to be disadvantaged.

Ageing ethnic minorities experience double (or triple) jeopardy (Norman 1985): ageism, racism, and language problems.

Nazroo et al (2004), using data from the 2001 Census for England, attempted to describe the experience of ageing for ethnic minorities. A key difference was that contact with family was significantly higher in Indian and Pakistani groups compared to the White group for 65-74 year-olds. But there were economic inequalities (eg: lower social class) for ethnic minorities (which were a continuation from earlier adulthood).

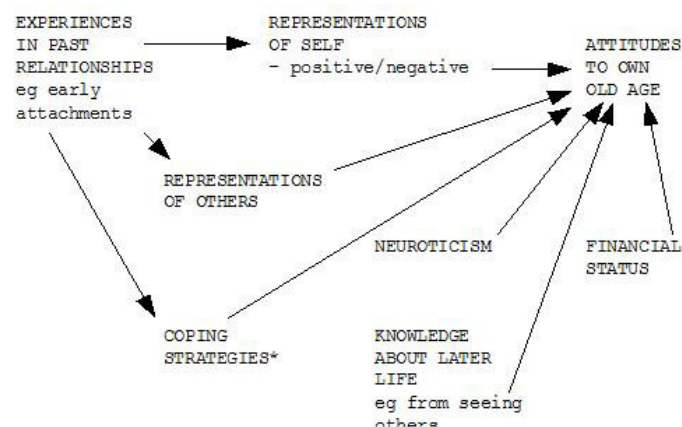
While "for those in the middle classes with the prospect of generous pension incomes, and who have planned for retirement, old age holds out the prospect of a prolongation of the plateau-like phase of adult life.." (Featherstone and Hepworth 1991 p374).

The experience of ageing today is within a specific context - globalisation or "turbo-capitalism" (Hutton and Giddens 2000). Put simply, globalisation "simultaneously brings home - and exports - the processes of privatization, competition, rationalization and deregulation as well as the transformation of all sectors of society through technology and the flexibilization

and deregulation of work" (Estes et al 2003 p106).

One upshot of this is the very different experience of ageing outside the West. Poverty and social exclusion dominate here, even more than for many older adults in the West.

How do individuals view their own ageing and future old age? O'Hanlon (2002 quoted in Coleman and O'Hanlon 2004) used open-ended questionnaires and psychometric tests via the internet with nearly a thousand adults (n = 942) of different ages, and face-to-face interviews with over three hundred adults in their own homes (n = 350). From the data, she produced a model to explain attitudes to own old age (figure 1). I would want to add the social representations of ageing in society to this model.



* Primary control strategies of adaptation; eg: getting help or secondary control strategies; eg managing emotions

(After Coleman and O'Hanlon 2004)

Figure 1 - Factors affecting attitudes to own old age.

QUALITY OF LIFE

Gabriel and Bowling (2004) reported details of the Quality of Life Survey in Britain in 2000 and 2001. The 999 respondents from across the country were asked about general quality of life and specific aspects of it. Overall 4% of men and 6% of women rated their quality of life as "so good it could not be better" (maximum mark), and less than 18% and 24% respectively gave the lowest rating.

The key components for a good quality of life included regular face-to-face contact with families, good relationships with neighbours and friends, keeping busy, and having a positive outlook on life.

Wealth is important to aid positive ageing, though having money does not automatically mean a good old age. However, a lack of wealth makes positive ageing a very difficult situation. There are concerns that older adults are disproportionately found in low income groups in Britain. Scharf et al (2004) undertook detailed research on material deprivation in Manchester, Liverpool, and Newham (London) with around six hundred adults 60 years or over.

Deprivation was based on seven criteria: no central heating, phone nor car; receiving income support; living in rented accommodation; more than one person per room; and no formal educational qualifications. Medium deprivation was defined as three or four of the criteria, and high deprivation as five or more. Scharf et al found that 57% of their White sample were classed as living in medium deprivation and 4% as high deprivation. This compares to 17% and 2% respectively for the general population.

The risk of high deprivation was even greater for women over seventy-five, those living alone, and older Pakistani and Somali adults.

Overall 45% of the sample were rated as living in poverty (based on a list of 26 "socially perceived necessities"; eg: two meals a day) compared to 21% of the general population.

The respondents were divided into three groups based on level of multiple deprivation (3) or social exclusion - "included" (no exclusion), "vulnerable" (exclusion in one way only), and "excluded" (multiple exclusions or deprivation). Not surprisingly the last group reported the poorest quality of life when interviewed (table 5).

	INCLUDED	VULNERABLE	EXCLUDED
Rated quality of life as:			
very good	47	37	15
poor	12	23	65
very poor	6	0	94

(After Scharf et al 2004)

Table 5 - Percentage replies to quality of life questions based on level of exclusion.

Do factors in quality of life change with age among the oldest-old? Berg et al (2006) looked at "life satisfaction" (4) among 315 adults over 80 years old in Sweden. Two factors were significantly associated with life satisfaction: quality of social networks (not size), and perceived control of life.

For women only, good perceived health and no depressive symptoms were important, and with men only, widowhood meant less satisfaction ⁽⁵⁾. These are all similar factors to other studies of quality of life in later life (eg: Jones et al 2003).

Theories

Traditional theories about post-retirement include social disengagement theory (Cumming and Henry 1961) ⁽⁶⁾, and activity theory (Havighurst 1964). The latter theory can be seen in Melia's (2000) study of how forty sisters of religious orders (aged 68-98 years) gave meaning to their lives by serving others.

Many theories of adult development stop at retirement age (eg: Levinson 1978). Erikson's (1950) theory is one of the few theories that covers the whole lifespan. The eighth stage (integration versus despair) is relevant to later life, but also a little known ninth stage (appendix 1).

Erikson (1968) defined integration as "the acceptance of one's one and only life cycle and of the persons who have become significant to it as something that had to be and that, by necessity, permitted of no substitutes". Ultimately, the aim is a "detached yet active concern with life".

The alternative is a sense of despair as "time is now short, too short for the attempt to start another life and to try out alternative roads to integrity".

An interesting case study for the despair aspect of the eighth stage comes from a Channel 4 documentary called "Bus Pass Boob Jobs" (2006). This focused upon three older adults who wanted or were undergoing cosmetic surgery. Much of what they said about wanting the surgery related to a desire to go back in time or start again.

For example, Sylvia Adams (65 years old), who was having breast implants, talked of "trying to recapture some of it" (her 30s). While Tony Day (in his 70s) wanted a facelift because he hoped that a new face would make him a different person and he could start again. For Erikson, failure to develop integration leads to feelings of regret, and despair because it is too late to try again.

Peck (1968) sub-divided Erikson's eighth stage into "ego differentiation versus work-role preoccupation" at retirement age, and "body transcendence versus body preoccupation" later. The former "crisis" to be resolved relates to coming to terms with not doing paid work. The latter is a "crisis" around the physical deterioration of the body.

GEROTRASCENDENCE

The idea of change of values in later life is central to the theory of gerotranscendence (Tornstam

1994; 1999). The individual shifts their focus from material concerns to "a more cosmic and transcendent one". Tornstam highlighted the signs of gerotranscendence as cosmic, self and relational characterised by:

- Increased feeling of communion with nature or "spirit of the universe";
- Development of a more "cosmic self" that is less concerned with here and now, and less self-centred;
- Changing attitudes towards death (with declining fear);
- An affinity to the past and future;
- Less interest in superficial social relationships;
- Less concern over material things.

Gerotranscendence can be described as an altered state of consciousness which is universal to old age irrelevant of the culture. Tornstam's ideas are based upon his surveys of the Swedish population (Tornstam 1997). Technically, younger individuals can experience gerotranscendence after a major life crisis.

Generally this theory and others are suggestive of a process of spiritual change or development with ageing. Studies have found equivocal results - some aspects of spirituality remain stable over the lifespan and some increase, but rarely is there a decrease. Table 6 summarises some of the studies. It must be noted that spirituality itself is a difficult term to define and measure (Dalby 2006).

STUDY	DETAILS
Spirituality stable	
Baker & Nussbaum (1997)	60 residents of US retirement community (aged 68 yrs+); postal questionnaire on religious practices, affective/cognitive/behavioural spiritual dimensions; asked to compare now with age 45
Black (1995)	150 US childless men aged 58-93 yrs; spirituality (belief in afterlife and supreme being) not important
Spirituality increase with age	
Wink & Dillon (2002)	130 older adults in US longitudinal study; significant increase in spirituality ("a personal quest for a sense of connectedness with a sacred other") from late-middle to older adulthood, especially for women; but overall spirituality low
Ahmadi (2001)	open-ended interviews with 29 Turks aged 66 yrs or more; Sufi Muslims showed "gerotranscendence", but not secular Turks

(After Dalby 2006)

Table 6 - Examples of studies on spirituality and ageing.

OTHER THEORIES

An alternative view upon ageing focuses upon "successful ageing" (maximising gains and minimising losses). Baltes and Carstensen (1996) defined it as:

..(T)he successful mastery of goals in the face of losses endemic to advanced age as a result of the interplay of selection, compensation and optimisation (p397).

Baltes et al (1999) developed the idea of selection, optimization, and compensation (SOC). The authors applied this model to an eighty-year-old concert pianist (Arthur Rubinstein):

- Selection: narrowing of options and concentration of limited resources; eg: played fewer concerts and pieces of music;
- Optimization: strategies to overcome limitations; eg: practise more;
- Compensation: use of alternative means to reach goals; eg: adjust the playing to hide any weaknesses.

While a senior athlete competes against their own age (selection), varies the preparation for the race; eg: longer warm-up (compensation), and adapts training; eg: shorter sessions (optimization) (Estes et al 2003).

Freund and Baltes (1999), as part of the Berlin Aging Study, found that older individuals who used SOC strategies had more positive emotions.

Other approaches to successful ageing include assimilation and accommodation (Brandtstadter et al 1998). Assimilation involves strategies that change the environment, and accommodation is the individual adjusting their goals in the light of ageing.

Looking at adulthood as a whole, Sheehy (1978) described a "second adulthood" beginning in the mid-40s. She also noted the age shifts in expectations from her first edition of the book in 1976, such that fifty is what forty used to be and sixty is fifty. This is due to a combination of changes in society, and longer life expectancy.

Another theory, the life course perspective (Neugarten and Hagestad 1976) viewed ageing individuals as a product of their whole lives and events that have

happened during that period (both individual and social).

Riley et al (1972; 1999) developed the "ageing and society paradigm" to understand ageing in a social context, particularly in terms of age stratification. Sociologists is now short, too short for the attempt to start another life and to try out alternative roads to integrity".

Ageism

Any understanding of the psychology of ageing and older adults has to be seen in the context of age prejudice in the West. Both the explicit and implicit messages about ageing are negative ⁽⁷⁾. Nelson (2005) called the process "the institutionalization of ageism":

Older persons today are treated as second-class citizens with nothing to offer society and the negative attitudes about ageing that give rise to ageism tend to manifest themselves in subtle ways in the daily life of the average older person
(Nelson 2005 p209).

Research on Age Discrimination (RoAD) asked forty older people to keep diaries on age discrimination. Examples reported included a seventy-three-year-old man who found dating agencies loathed to accept his membership, or the fact that fashionable clothes and hairdressers cost too much for low incomes. "Annette" told this story:

In the summer I like to wear shorts you see, shorts and just strappy tops, and I got quite a few nasty remarks about showing myself up, because I was dressing like a teenager (vignette 14 at www.road.open.ac.uk accessed 15/8/06).

Ageing is always seen as a problem because vested interests gain from such ideas, according to Estes (1979): "This creates a series of powerful voices that drown out the experiences of older people themselves, and restricts the 'problem of ageing' to those that these enterprises can profit from.." (Estes et al 2003 p65).

The authors here are arguing that this process distracts from the inequalities and discrimination against older adults as well as the decline in the quality of welfare services in recent years.

The manifestations of ageism can be seen in a number of ways (Nelson 2005):

i) Patronising language

For example, over-accommodation in speech which involves being overly polite, speaking louder and slower, exaggerating intonation, and talking in simpler sentences (Giles et al 1994).

Kempe (1994) observed the speech of caregivers in a nursing home. Sentences were repeated and speech was

slower irrelevant of the cognitive state of the older adult. Age was the trigger to such behaviour because the stereotype of older people is hearing problems, and declining intelligence.

Taking it further, Caporael (1981) noted the use of "baby talk" (or "secondary baby talk") with older adults. This is a version of the simplified language used with babies. Older adults with lowered cognitive abilities did prefer it, while those with normal functioning found it condescending and humiliating (Caporael et al 1983).

ii) Self-fulfilling prophecy

The power of society's expectations and attitudes can make older adults take on the passive and dependent stereotype role through the self-fulfilling prophecy (Arluke and Levin 1984).

Giles et al (1994) found that independent observers rated older adults receiving over-accommodated speech as looking and behaving older than the control group not receiving that speech.

Older people, in this context, are cautious about calling themselves "old". For example, Midwinter (1991) found that 72% of the elderly people questioned preferred the terms "senior citizen" or "retired", and only 4% used "older people".

iii) Helping professions

Levensen (1981) noted that US medical students' negative attitudes towards older adults was "surpassed only by their racial prejudice". He was critical of the whole of the medical profession and their attitude that ageing inevitably led to physical deficits. Many physical conditions can be improved as is the case at all ages (eg: high blood pressure, diabetes).

Negative attitudes have also been found among psychiatrists and therapists including the belief that the psychological problems of older adults are not as serious as those of younger ones (Ivey et al 2000), or the greater likelihood of prescribing drugs rather than therapy for depression (Ford and Sbordonne 1980). Gekoski and Knox (1995) preferred to talk of "healthism" (rather than ageism) here. This is the stereotype of individuals with poor physical health at any age.

Estes et al (2003) stated that "biomedicine changes the way in which old age is perceived. Primarily, age becomes associated with illness, and if illness can be abolished, perhaps also can age" (p81). Under the "medical gaze", individuals become their bodies, and in

particular, the parts that need mending (Foucault 1973).

iv) Elder abuse

This abuse includes neglect by caregivers, violence, fraud, or exploitation. It is probable that ageism contributes to this problem, and also its under-reporting (Quian and Tomita 1986) ⁽⁸⁾.

Elder abuse can also have a "passive" version including removal of treasured possessions by staff or putting patients to bed early in residential care (White 1999).

Different theories have been proposed to explain ageism. One view is that age prejudice has an ego-protective function for younger individuals. Negative stereotypes allow the younger individual to reduce the threat to their self (Snyder and Meine 1994).

Taking this idea a step further, Terror Management Theory (Greenberg et al 1986), focuses upon how individuals cope with the fear of death. Distancing oneself from the reality of mortality is done in different ways including negative attitudes to those individuals associated with death (ie: elderly).

"In so doing, the young perceiver convinces him/her self that such a fate is not in his/her own future, thus alleviating the anxiety" (Nelson 2005 pp214-5).

Self and Identity

The self is viewed as an active process in response to the reactions of society towards ageing rather than as passive (Coleman 1996). Where individuals are coping with their self identity in a negative or critical environment, this is known as the "management of identity" (Atchley 1989). Older adults are having to actively manage their identity in the context of ageism and the stigma of being old.

The active self is seen as the individual reflecting upon their attitudes, ideas, and behaviour in relation to the reaction of others and society. Ryff (1989), for example, noted that older adults saw accepting change as key, while middle-aged adults emphasised self-acceptance.

Making sense of the self is always in the context of comparison with others. Ryff and Essex (1992) interviewed older women experiencing relocation (for example: from home to residential care). Those women with positive feelings about themselves and their well-being felt that they compared favourably to the other people around them, and perceived that their family and friends were positive about how the individual was responding to the change.

Longitudinal studies (eg: Johnson and Barer 1992 in San Francisco) are showing that over-85s have very positive views of themselves. For example, feelings of loss over regular bereavements is compensated by the "special status" of survivor.

CHANGES IN SELF

Older adults seem to become more accepting of themselves. Ryff (1991) found the smallest difference between ideal self and actual self in the oldest adults in her study of three age groups (mean ages 19, 46 and 73 years).

Self-esteem does not inevitably decline in later life. In fact, in a large German study using sentence-completion to describe themselves, older participants were more positive towards themselves and less harsh, even about physical appearance, compared to younger people (Dittmann-Kohli 1990).

However, Tunaley et al (1999) who interviewed in depth twelve women aged between sixty-three and seventy-five years old found contradictions between dissatisfaction with the women's bodies compared to the "thin ideal" and this stage of life as a time of freedom from social norms. This was shown by beliefs about the

inevitability of weight-gain with age.

One aspect of the self that has been studied recently is "individuality" ("experience of the own person as a coherent whole clearly separate from other persons") (Westerhof and Bode 2006). The opposite is "relatedness" ⁽⁹⁾. Westerhof and Bode (2006) used the data from the Dutch Aging Survey, based on three age groups (40-54, 55-69, and 70-85 years old), to study this distinction. It was found that "individuality" declined with age, while women generally rated "relatedness" higher. The authors interpreted these findings as evidence of adaptability in older adults to focus upon others as they age.

SELF IN OLDEST OLD

Three themes can be drawn out from the research on the self among the oldest old.

i) Perceived stability of self across lifespan

Troll and Skaff (1997) interviewed predominantly women over the age of 85 years in San Francisco at two points in time two and half years apart. The first interviews involved 144 people and the second only ninety still alive. The semi-structured interviews were based around the question "In what ways have you changed over the years?". The majority (74%) felt that they were essentially the same person, and only 18% answered that they had changed somewhat.

ii) Differences in self between younger-old and older-old

Freund and Smith (1999), using the Berlin Aging Study, compared 70-84 year-olds with 85 years plus adults using the "Who Am I" method. The answers were scored on twenty-four categories (eg: social roles), and as positive or negative. Both groups gave more positive than negative answers, but the older-old gave more negative answers than the younger-old.

There were significant differences on five categories of scoring including fewer outdoor activities and hobbies by older-old, and families mentioned less.

iii) Self-esteem

The longitudinal study in Southampton over twenty years and eight observation points has questioned

participants using a bipolar self-esteem measure (eg: useful-useless) (Coleman et al 1999). Self-esteem was measured in relation to family relationships, other relationships, health and independence, interests and hobbies, inner self beliefs, quality of life, and work roles. The participants were in their 60s at the beginning of the study. Overall, self-esteem showed only a small decline.

A comparison of data from 1977-8 (average age 71 years) and 1990-1 (average age 84 years) showed some change, but mostly stability. The change was that interests and hobbies had become the most important indicator of self-esteem by the second time point. While the other factors remained important - namely health and independence, and family, and other relationships. In other words, individuals with lots of interests who were healthy and had good relationships showed higher self-esteem irrelevant of age, and the opposite for less interests and poorer health and relationships.

THE BODY AND POST-MODERN IDENTITY

The body image is traditionally seen as an important part of the self concept in psychology.

Hockey and James (2003) noted that "our perception of the world is always sited in a particular experience of embodiment". Thus as the body ages, so the perception of the self will change. But it is not as simple as that because, in modern Western societies, ageing and illness have become seen as the same thing. Individuals are not only coping with physical change, but with the negative assumptions about these changes.

Figure 2 shows the factors that can affect the perception of the body and the self. But this process is now taking place within the post-modern world with the situation that because "our world can no longer tell us who we are and how we should live, we must figure it out on our own" (McAdams 1993). The pre-existing structures of life stages are blurred, and the individual is left to negotiate their own identity.

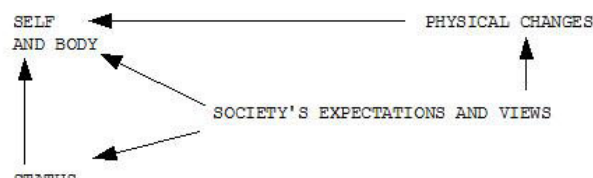


Figure 2 - Factors affecting the perception of the body and the self in later life.

The issue of identity in modernity ⁽¹⁰⁾ was "to keep one's personal world relatively stable and predictable" during social change, whereas the post-modern identity is about avoiding factors that may "constrain the options open to people as they age" (Estes et al 2003). The modern identity was based upon production (ie: work) and the end of production (retirement). The post-modern identity is about consumption: "under post-modern conditions, an ageing identity maintains its buoyancy through the purchasing of lifestyles and props to support it" (Estes et al 2003). For example, older adults, particularly wealthy, are in 21st century Britain, "'ageless' consumers in a privatised and medicalised market" (Biggs 2006). It is possible to see the elderly as having a role in society now as consumers.

There is now fluidity in the life course, meaning that different aspects of ageing happen at different ages rather than all assumed at a set age. And secondly, the body becomes an area of contention in post-modernity. This means that the signs of physical ageing can be hidden (or reversed?) by lifestyle and medical technology. Rich elderly can free themselves from the "tyranny of the flesh". In all these cases, post-retirement income is the key.

The views on ageing have changed, from the:

..(I)nter-war phase when "the elderly" were expected to don the retirement uniform, the postmodern times when older citizens are encouraged not just to dress "young" and look youthful, but to exercise, have sex, take holidays, socialise in ways indistinguishable from those of their children's generation (Blaikie 1999 p104).

For identity, this means that "older adults are expected to generate identities from their own imaginative resources, as the certainties of stage-appropriate codes of behaviour appear to be dissolving in front of their eyes" (Estes et al 2003 p36).

Under conditions of post-modernity, self-regulation becomes important as traditional social structures and conventions are eroded. This self-regulation is shown through the body in terms of diet, exercise, and personal appearance. In fact, for Turner (1995), the body is now self-identity.

But there is a conflict that emerges for older adults between what they want to do and what they can do with their bodies. Featherstone and Hepworth (1991) talked of the "mask of ageing" - where younger self-identity is trapped inside an ageing body like in a cage:

..(T)he visible ageing body disguises the ever-youthful self within, or, on the other hand, the external surface appearance is used as a template to present various personae, all of which with the aid of cosmetics and other props, can be used to reveal "the self we would like to be" that is otherwise concealed by the bodily signs of age..
(Blaikie 2006 p85).

Whether options are more open and available to older adults, there are contradictory restrictions at the same time. For example, older women are pressurised to look physically attractive and sexy, while at the same time criticised for doing so (eg: "mutton dressed up as lamb"). Contradictions are inherent in post-modern society for me (Brewer 2002c).

Pathological Ageing

Mental illness, including dementia, affects only a minority of older adults (eg: 13% vs 19% in general population; Meltzer et al 1996; UK Government figures) despite the stereotype that is an inevitable part of ageing ⁽¹¹⁾. On the other hand, older adults' psychological problems can be ignored or downplayed in importance.

Establishing the exact rates of mental disorders is a problem generally, and depends upon the methodology and sampling used.

For example, Ritchie et al (2004) randomly recruited 1873 non-institutionalised over 65s from Montpellier, France. Table 7 summarises some the findings.

PREVALENCE (%):	CURRENT	LIFETIME
Major depressive episode	3.1	26.5
Any phobia	10.7	21.6
Generalised anxiety disorder	4.6	10.8
Psychosis	1.7	4.7
Suicide: thoughts	9.8	-
attempts	-	3.7
Any disorder	17.0	45.7

(After Ritchie et al 2004)

Table 7 - Rates of different mental disorders in French sample.

The prevalence of mental disorders are not the same across the lifespan - some clearly decline with age (eg: substance use disorders), others remain fairly constant (eg: anxiety disorders), and some increase with age (eg: severe cognitive impairment) (Gelder et al 2006).

However, in an extensive study of 35 014 individuals in Iran, the prevalence rate of mental disorders was calculated as 31.5% for over 65s, which was higher than the other age groups (eg: 17.6% 15-24 year-olds; 25.0% 45-64 year-olds) (Noorbala et al 2004).

Again the level of mental disorders across the lifespan will depend upon the study ⁽¹²⁾. Table 8 shows the figures from the US using DSM-III (APA 1980) criteria for the previous month. Table 9 contains the data from the "PATH Through Life Project" in Canberra, Australia (Jorm et al 2005), which studied three age groups (20-24, 40-44, and 60-64 years old) for anxiety and depression. This study used the Goldberg anxiety and depression scales (Goldberg et al 1988) which have nine items each for assessment over the previous month. In table 10 are the comparisons of rates of mental disorders from a selection

of studies using different methods and samples.

	65 years and older	Younger than 65 years
Phobic disorder	4.8	6.2
Panic disorder	0.1	0.5
Obsessive-compulsive disorder	0.8	1.3

(After Lindesay 1997)

Table 8 - Percentage rate in last month of three mental disorders in the US using DSM-III criteria.

ANXIETY	MALE	FEMALE	ALL
20-24 yrs	3.20	4.44	3.84
40-44	3.29	3.72	3.52
60-64	2.00	2.50	2.24
ALL	2.80	3.56	
DEPRESSION			
20-24	2.58	3.18	2.89
40-44	2.28	2.55	2.42
60-64	1.58	1.78	1.67
ALL	2.12	2.50	

(After Jorm et al 2005)

Table 9 - Mean scores (out of 9) for three age groups in "PATH Through Life Project".

As with other age groups, the rate of mental disorders is greater among lower income groups. For example, using British Government figures for 2000, 16% of women aged 60-74 years reported a "neurotic disorder" (including depression, anxiety, obsessive-compulsive disorder, panic disorder, and phobic disorder) in households with a weekly income of under 100. The figures were 6% for households with income above 500, and 14% for the whole age group (Office for National Statistics 2004).

DISORDER	OLDER ADULTS	GENERAL POPULATION
Anxiety disorders	6% (70 yrs) - 10% (85 yrs) (3); 14% (4)	4.7% (1); 13.5% (2)
Psychotic disorders	1% (70 yrs) - 5% (85 yrs) (1)	1% schizophrenia (2)
Mania	0.1% over 64s (5)	1.4% of under 45s (5)
Personality disorders	7-10% over 50s (6)	5-9% (7)
Any disorder	26.3% (8)	20.0% (2)

- (1) Jenkins et al (1997) 1 week prevalence in UK community sample
(2) Robins and Regier (1991) 1 year prevalence in US community sample
(3) Skoog (2004) Sweden
(4) Ritchie et al (2004) French sample using DSM-IV criteria
(5) Weissman et al (1988) 1 year prevalence in US ECA study
(6) Abrams and Horowitz (1996) meta-analysis of other studies
(7) Samuels et al (2002) Baltimore community sample
(8) Kay et al (1964) Newcastle-upon-Tyne study

Table 10 - Rates of mental disorders for older adults compared to the general population.

DEPRESSION

Rates of depression for older adults, for example, vary between 8-15% in the US (Baldwin et al 2002), 12.3% in Europe (Copeland et al 1999), and 13.5% worldwide (Beekman et al 1999). More recently, Kim et al (2006) reported depression in 12% of 732 community residents in South Korea.

But the rates also vary depending upon the sample studied; eg: hospital patients (10-45% rates) and those in residential homes (30-45% rates) (Baldwin et al 2002).

There is debate over how the rates of depression in old age compare to the general population. Studies using major depressive disorder found no change or less with age, while those based on minor depressive disorder (13) reported an increase (Baldwin et al 2002).

After their review of the evidence, Blazer and Hybels (2005) concluded that:

Older adults appear to be at greater risk for major depression from some biological causes.. yet the frequency of majority is lower..(and)..there is reason to believe that older adults who are cognitively intact and who do not suffer from significant functional impairment maybe protected psychologically.. and perhaps protected from some social risk factors compared to younger adults (p1249).

Concerning the course of the illness, Beekman et al (2002), in a six-year longitudinal study, found that 32% had depression that did not recover, 44% had fluctuations in improvement, and the remainder recovered.

Blazer (1991) felt that certain depressive symptoms clustered together in a unique way among over 60s living in residential communities. These symptoms were low mood, psychomotor retardation (lack of movement), poor concentration, constipation, poor perceived health, cognitive deficits, and an association with physical ill health.

A new category of "vascular depression" has been proposed for older adults (Alexopoulos et al 1997). This is due indirectly to a stroke (ischaemic brain damage), and is a type of depression only arising in later life. It involves less depressive thoughts than "normal depression", and more cognitive impairment.

Gelder et al (2006) referred to a condition called "depressive pseudodementia". The individual appears to be suffering from dementia, but the symptoms are actually related to depression. This can be seen in table 11 which compares the cognitive deficits in three mental disorders.

	DEPRESSION	DEMENTIA ALZHEIMER TYPE	OTHER DEMENTIA
Verbal IQ	-	mild to moderate	
Performance IQ	mild	mild to moderate	
Mental speed	mild	mild to moderate	
Motor speed	-	-	mild to moderate
Language	-	mild to moderate	
Verbal memory	-		marked
Non-verbal memory	mild		marked

(After Sadock and Sadock 2003)

Table 11 - Cognitive deficits in three mental disorders.

If depression does increase with age, then there are specific life events that play a key role including the loss of loved ones, and negative experiences of being in a residential or nursing home (Mottram et al 1996).

Blazer and Hybels (2005) listed risk factors (particularly biological ones) for depression generally as well as specific to older adults (table 12). There are two factors, the authors reported, that protected older adults from depression - wisdom, and focus on already-

existing close relationships (socioemotional selectivity; Carstensen 1992).

GENERAL RISK FACTORS	SPECIFIC RISK FACTORS
- hereditary	- genetic mutations
- female	- low levels of dehydroepiandrosterone (DHEA)
- underactivity of serotonin	- cortical/sub-cortical ischaemia (stroke)
- hypersecretion of cortisol	- Alzheimer's
- low testosterone	
- medical illness	
- alcoholism	

(After Blazer and Hybels 2005)

Table 12 - Biological risk factors for depression both general and specific to old age.

Marottoli et al (1997) found a link between depression and cessation of driving in 1316 non-institutionalised over 65s in New Haven, USA. This sign of loss of independence produced an increase in depression for the following few years, but then it declined.

In a New Zealand study, Alpass and Neville (2003) discovered that it was self-rated health as much as actual health that was linked, with other factors, to depression. So individuals who self-rated their health as lower than it actually was, were more likely to be depressed.

Dennis et al (2005) concentrated upon a sub-group of depressed older adults who deliberately self harm. Forty-eight such adults aged 65 years and over were compared to fifty same aged adults with depression only. All participants were given a semi-structured interview based around six psychometric scales, including the Geriatric Depression Scale (GDS-15; Sheikh and Yesavage 1986), the Life Events and Difficulties Schedule (LED-2; Bifulco et al 1989), and the Suicide Intention Scale (SIS; Beck et al 1974) ⁽¹⁴⁾.

The self-harm group had a higher average SIS score suggesting "significant suicidal intent" (67% of participants had wished to die). This group were more likely to respond "yes" to the question: "Do you feel

your situation is hopeless?" on the GDS-15. Finally, the self-harm group were more lonely, and poorly integrated in the community with a lack of support services. Both groups had experienced similar amounts of severe life events in the last six months.

Elford et al (2005), in a preliminary study, have found that autobiographical writing can help older adults who are depressed in residential care homes. Four residents in South Yorkshire, aged between 71-89 years old, were asked to write (and talk) about aspects of their lives. Brief qualitative interviews one month later produced positive feedback.

SUICIDE

Does suicide behaviour increase or decrease with age? This is not easy to answer because of the methodological problems of measuring suicide. The general view is that it increases.

In the US, in 1999, 32 000 people killed themselves, of which 6200 were elderly (Salvatore 2000). Furthermore, the suicide rate for over 65s was five times the US general population rate, and six times for over 85s. The rate of suicide for 80-84 year-olds has increased 35% between 1980-92 (Baldwin et al 2002).

In most countries, the highest standardised rate of suicide is among over 75s (Gelder et al 2006). But in India, suicide becomes less frequent with age (Lindesay 1991).

Men most commonly use hanging and women drug overdose (Harwood et al 2000).

In a survey of 100 suicides in the UK, Cattell and Jolley (1995) reported that at least 60% had been depressed, and 65% had physical illnesses.

Snowden (2001) analysed the coroners' records for Sydney, Australia to find the possible motivation for 210 suicides by older people. Depression was key in most of the suicides (table 13).

Measuring Suicide

The figures on the number of suicides are not straightforward to interpret because different calculations produce different impressions of whether suicide is higher in the older age groups.

i) Counting the number

A simple counting of the number of suicides showed that less older people died this way in England and Wales

NUMBER (%)	REASON
25	recent loss/depressed
24	release from physical suffering/two-thirds depressed
18	depression without obvious external cause
13	difficult situation; eg: financial problems
10	depression linked to disability or illness
6	other mental disorder including dementia/two-thirds depressed
4	uncategorised

Table 13 - Possible reasons for suicide by 210 older Australian adults.

in 1998 (table 14). But these figures are not really comparable because the older age group is a smaller population relative to other ages. Official figures also include undetermined injury which may or may not be self-inflicted, or the coroner may use this type of term to help the family with the stigma when suicide is unclear.

	MALE	FEMALE
15-64 years	3672	985
65-74 years	253	160
75 years +	249	171

(After Bird and Faulkner 2000)

Table 14 - Suicide, self-inflicted injury and undetermined injury deaths for England and Wales, 1998.

ii) Percentage of age group

Some Government figures on suicidal behaviour seemed to show a decrease with age in Britain in 2000 when the percentages for the age group are calculated (table 15) (Meltzer et al 2002). Though these figures relate to anytime in life and not just recent.

	SUICIDAL THOUGHTS IN LIFETIME	SUICIDE ATTEMPT IN LIFETIME
65-74 years	11%	11%
16-64 years	18%	18%

(After Meltzer et al 2002)

Table 15 - Suicidal behaviour by age in Britain, 2000.

iii) Percentages of total suicides

Duffy (1997) estimated that one-quarter of all UK suicides in the mid-1990s were by over 65s (who made up 15% of the total population at the time of the study).

Between 1996 and 2000, 20 927 deaths were recorded as suicide or open verdicts in England and Wales, of which 3668 (17.5%) were by adults 65 years or older.

iv) Standardised rates

It is much better to calculate the figures as standardised rates (eg: per 1000) as this allows a better comparison of groups of different sizes. Table 16 shows the standardised figures for suicide and death from undetermined injury in the UK in 2002. The highest rate of suicide was young and middle-aged men.

	MALE	FEMALE
15-24 yrs	13.3	3.7
25-44	24.1	6.4
45-64	17.9	6.4
65 +	13.5	5.8

(After Office for National Statistics 2004)

Table 16 - Suicide rates per 100 000 population in the UK in 2002.

The overall figures hide clear gender differences, and differences around the UK (table 17) (Fitzpatrick et al 2001).

RATES PER 100 000		MALE	FEMALE
UK	OVERALL	15	5
	65 yrs+	18	7
Significantly lower than UK rate for:			
65 yrs+		NW England; Northern Ireland	NE England; NW England; Northern Ireland
Significantly higher than UK rate for:			
65 yrs+		Scotland	Scotland

(After Fitzpatrick et al 2001)

Table 17 - Age-standardised mortality rates for suicide and undetermined injury in the UK, 1991-7.

Figures for the last thirty years have tended to show that suicide rates for men increases with age (table 18), and has increased in recent years.

RATES PER MILLION POPULATION

	OVERALL	65-74yrs	75yrs+
England and Wales			
1974	95	189	196
1988	125	162	243
Northern Ireland			
1974	51	43	96
1988	156	145	111
Scotland			
1974	103	214	168
1988	173	129	241

(After Pritchard 1992)

Table 18 - Male suicide rates 1974-88.

v) Odds ratio

The odds ratio calculates the likelihood of a behaviour in relation to a comparison group. For example, Crawford et al (2005) showed that the odds ratio for lifetime suicidal thoughts among ethnic minorities in England is much lower than the White population (table 19). They used data from the Ethnic Minority Psychiatric Illness Rates in Community (EMPIRIC) study of 4281 respondents aged 16-74 years in England.

ADJUSTED ODDS RATIO (White = 1.00)

Irish	0.44 *
Black Caribbean	0.16 *
Bangladeshi	0.25
Indian	0.32
Pakistani	0.25

(* = significant difference to White population)

Table 19 - Odds ratio for lifetime thoughts of taking own life in 55-74 age group based on ethnic minority.

DEMENTIA

Dementia prevalence increases with age from 1 in 1000 pre-65 years old to 1 in 5 over 80s, and nearly 40% of 95 year-olds (Gelder et al 2006). But note that it is still a minority suffering even over 80 years old. Table

20 gives the rates from the USA (Sadock and Sadock 2003).

	ALL OVER 65 YRS	OVER 80 YRS
Any dementia	1.5	16-25
Severe dementia	5	20

Table 20 - Rates of dementia (%) in US based on age group.

Again the rate of dementia varies depending upon the study. Table 21 gives some examples of different rates from studies around the world for over 65s, while table 22 shows age and gender differences.

STUDY	SAMPLE	FINDINGS
Campbell et al (1983)	541; New Zealand	7.7% severe or moderate dementia (includes institutionalised adults)
Evans et al (1989)	3623; Boston	10.3% any dementia
Li et al (1989)	1331; Beijing	1.8% severe/moderately severe dementia
Livingston et al (1990)	705; Gospel Oak, London	4.7% severe or moderately severe "pervasive dementia"

Table 21 - Examples of different rates of dementia around the world.

	MALE	FEMALE
65-74 yrs	3.5 - 5.7	2.8 - 7.3
75-79	7.0 - 15.0	9.8 - 37.6
80 -84	10.1 - 24.0	18.5 - 41.0

(After Cooper 1997)

Table 22 - Rates of dementia per 1000 based on gender and age.

Dementia is defined as having three key symptoms by ICD-10 (WHO 1993), and diagnosed at mild, moderate, or severe levels (table 23).

But dementia as a category is not without its critics. Kitwood (1995), for example, called it a "deeply paradoxical category".

SYMPTOM	MILD	MODERATE	SEVERE
1. Decline in memory	"interfere with everyday life"	"serious handicap to independent living"	"complete inability to retain new info"
2. Decline in other cognitive abilities eg: judgment, thinking	"impaired performance in daily living"	"unable to function without assistance of another"	"absence, or virtual absence, of intelligible ideation"
3. Decline in emotional control or motivation, or change in social behaviour	eg: apathy		

Table 23 - Key symptoms of dementia in ICD-10.

Neither is dementia inevitable nor untreatable. Cheston et al (2003) reported the benefits of ten weeks of group psychotherapy for nineteen patients, both in terms of improving dementia symptoms as well as anxiety.

The mean survival time from clinical onset is estimated at five to 9.3 years (Shigeta and Homma 2002). The greater risk of death from dementia is for male sufferers, and/or individuals with physical illness as well (Shigeta and Homma 2002).

Alzheimer's Disease

Alzheimer's disease is a type of dementia first noted in 1901 by Alois Alzheimer. It is often referred to as Dementia Alzheimer Type (DAT). Of an estimated 600 000 sufferers of dementia in the UK, 55.6% had DAT (Ginns 1998). In the US, 21% of men and 25% of women aged ninety or older were suffering (Sadock and Sadock 2003).

There seems to be a distinction between early onset DAT (ie: before 65 years old) which has a genetic basis (eg Nurnberger and Berrettini 1998), and late onset with environmental causes.

There are three broad stages of DAT (Ginns 1998):

i) Increasing forgetfulness, particularly for recent events and those of personal significance;

ii) Declining concentration and numerical ability with problems finding the right word (dysphasia) leading to anxiety and personality change;

iii) Disorientation and confusion; sometimes psychosis, aggression or docility.

There are a number of risk factors for the development of DAT: family history of dementia, Parkinson's, or Downs Syndrome being the strongest (Cooper 1997). Recent research has suggested that subjective episodic memory problems may appear over three to five years before DAT, and before objective memory tests find any problems (Zaudig 2002).

Bere Miesen (1998) has applied attachment theory to understanding dementia sufferer in an interesting way. The loss of memory produces feelings of insecurity which is like the young child in the "Strange Situation" (Ainsworth et al 1971). For example, sufferers called for their deceased parents ("parent fixation") which can be likened to the young child crying when left alone in the "Strange Situation".

Two areas of research interest are dominant in recent years. Firstly, the clinical work on drugs to treat (slow down) the onset and effect of DAT; eg: Rosler et al (1999) rivastigmine (selective inhibition of acetylcholinesterases). Secondly, the search for genes involved in early onset DAT; eg: presenile gene 1 (chromosome 14) (Brindle and St.George-Hyslop 1998).

A different area of focus, to a lesser extent, is upon the carers/relatives of sufferers of DAT. Research shows that the stress of caring can effect the immune system.

Kiecolt-Glaser et al (1996) compared elder carers of spouses with progressive dementia with matched controls during the routine seasonal influenza virus vaccination. The carers had clear evidence of compromised immunity.

Caregivers in other similar studies have been found to have higher cortisol levels, which suppresses antibody response to vaccination. Of fifty carers of spouses with dementia, only 16% produced a four-fold increase in antibody levels (as expected after the vaccination) compared to 40% of the sixty-seven controls (Vedhara et al 1999).

On another measure of suppressed immune functioning, caregivers of DAT sufferers took 25% longer to heal than controls. It took an average of 48.7 days for a 3.5mm punch wound to heal among thirteen carers as opposed to 39.3 days in the control group (Kiecolt-Glaser et al 1995).

From a different standpoint, Sabat and Harre (2000) attempted to understand the construction of the self for DAT sufferers through discourse analysis. Sabat (2001)

also distinguished between the loss of a "social self" (based on others' reactions), and a "personal self" (use of first-person). The latter remains longer in dementia. The problems in communication and social interaction lead to "the fencing off of the sufferer so that no adequate self can be constructed".

One group who suffers from high rates of dementia are adults with learning disabilities. Rates vary but prevalence can be higher than 80% in some studies (Holland 1999). Individuals with Downs Syndrome can be prone to early onset dementia (appendix 2).

OTHER MENTAL DISORDERS

There are some rare mental disorders that appear to be unique to old age.

Schizophrenia-like Disorder ("very-late-onset-schizophrenia-like psychosis" or late paraphrenia)

There are rare cases of schizophrenia-like disorder developing after aged sixty. Usually schizophrenia occurs in early or middle adulthood (Gelder et al 2006). Certain symptoms are more common than in schizophrenia (eg: visual, tactile or olfactory hallucinations), and others less common (eg: thought disorder) (Howard et al 2000).

Senile Squalor Syndrome

Characterised by severe neglect of the self and surroundings with social withdrawal, and hoarding of rubbish (sylllogomania) (Gelder et al 2006). It is also known as Diogenes' syndrome (Clark et al 1975).

Charles Bonnet Syndrome

This is the occurrence of visual hallucinations without psychosis or dementia, but in the presence of deteriorating vision. There are no universally agreed diagnostic criteria, though it is estimated to occur in 10-15% of individuals with visual impairment (Jacob et al 2004).

Relationships in Later Life

Blieszner (2006) noted that "People in their 80s have had an entire lifetime to develop the skills they bring to their close relationships and evaluate their feelings about social partners. In fact, they have known their siblings and some friends for virtually their whole lives" (p2). She then asks whether this fact makes relationships in later life different to those of teenagers.

Blieszner recommended looking at the relationships of older adults from a life span perspective. This perspective focuses on adapting to challenges at different stages of life (Baltes et al 1998). In old age, where the capacity to deal with challenges is limited, this means that individuals will concentrate on the most important relationships and ignore casual ties.

Carstensen (1992) formalised this idea as the socio-emotional selectivity theory. In other words, "emotional resources" are shared out very carefully, and to a limited number of people.

Carstensen et al (1999) compared three age groups: first-year undergraduate students who concentrate on making new friends, newly-weds who spend time together, and older couples who "accept their relationship as it is" and "appreciate what is good, and ignore what is troubling". The first two relationships are future-oriented, while the latter is present-oriented.

Coleman and O'Hanlon (2004) partly disagreed, and argued that older people still use relationships to "bank information for the future" (15).

Support for the socio-emotional selectivity theory comes from Fung et al (1999), who used participants from the US and Hong Kong in four different studies to show that when time is limited, adults prefer people they know to meeting new people (table 24):

Study 1 - Participants aged 8-93 years in the US, recruited from telephone directories, given two scenarios with open-ended time (eg: if you have time to spare who would you share it with). Here 66% of older adults preferred familiar people for interactions versus 52% of younger adults;

Study 2 - Hong Kong participants aged as above given same scenarios, and another one with time limited (eg: emigrating soon). In the same scenarios, the results mirrored study 1, 59% of older adults preferred familiars (versus 47%). But in the time-limited scenario, all ages preferred familiar people;

Study 3 - Participants in Hong Kong interviewed prior to Hong Kong being handed back to China (creating a perception of limited time). All ages preferred familiar people;

Study 4 - Participants in Hong Kong one year after it was handed back to China (no perception of limited time). The results were similar to study 1.

Preference for familiar people (vs meeting new ones) (%)	OLDER ADULTS	YOUNGER ADULTS
Study 1 - control; USA	66	52
Study 2 - control; HK	59	47
- emigrating soon	90	89
Study 3 - time limited	70	62
Study 4 - open ended time	76	48

Table 24 - Results of Fung et al (1999).

An alternative view of ageing and relationships can be seen through that of life course transitions. Bengtson and Allen (1993), for example, understood current relationships in the context of the family, as well as past experiences and relationships. The former can be seen in the example of the age of grand or great grandparenthood (16) or events that are happening to the children. Early experiences of close relationships are relevant to later relationships.

Older adults will have a number of different types of relationships, some which are common to all age groups (like spouses/lovers, friends, and siblings), and those distinct to ageing (carers, children, and especially grand and great grandchildren). While common experiences of relationships, like seeking emotional support from friends and lovers, will be expressed in different ways in different times and places, and at different ages.

Overall, relationships in later life are less studied than relationships in younger adults, but a number of themes emerge (some relevant to all relationships, some not).

1. Social context

This area focuses upon where the relationship is taking place - for example, within the family or in a nursing home. Also relevant here is how elders are viewed in relation to including them in conversations or

speaking to them in an "infantilizing manner" (Blieszner 2006).

2. Historical context

The era in which individuals have grown up has an affect upon their relationships, including the attitudes and expectations of the time. Factors also include the growth of non-traditional family units in recent years (eg: stepfamilies, and gay or lesbian households), geographical proximity of family members, and number of offspring.

Blieszner and Roberto (2006) have studied "baby boomers" (individuals born soon after World War II), and events they experienced which will influence their relationships today as older adults. As teenagers in the 1950s and 1960s their attitudes and experiences were very different to those individuals born in the 1920s and 1930s; eg: openness, honesty, and free expression of feelings.

3. Personal development and social support

Recent general research on relationships has emphasised the importance of close relationships in individual personal development (eg: Stevens 1996). It is often forgotten as relevant to older people.

However, the way the individual views the future is relevant (Lang and Carstensen 2002). Older adults who perceived their time left as limited tended to focus upon the emotionally meaningful aspects of relationships now more than those who viewed their time left to live as less limited. In reference to the earlier point, the focus is even more on the existing close relationships at the expense of casual ones.

In terms of the practicalities of caring for older people, the burden is traditionally upon women in the family (or professionals). This limits the opportunity for contact even further. Studies in the US have also found ethnic differences in the area; eg: White caregivers of Alzheimer sufferers reported more exhaustion than African-American carers (Morycz 1993).

However, social networks of older adults are not static. Remarriage by themselves or their offspring produce new family members as well as reunions between adopted children and their birth parents (eg: Gladstone and Westhues 1998).

The oldest-old may also have symbolic relationships

with deceased individuals (Blieszner 2006).

Berkman and Syme's (1979) nine-year extensive longitudinal study showed the benefits of social networks as social support. They followed 4725 adults aged between 30 and 69 at the start of the study in Alameda County, California.

Each participant was given a "connection" rating based on number of people known and intimacy of relationships. Mortality was measured at nine years. Table 25 shows the results for the 60-69 age group, which like all age groups showed that more social support was associated with lower mortality.

More recent research has found the benefits of social support in protecting against the risk of depression in older adults (Blazer 2005). For Tiikkainen and Heikkinen (2005), it is a particular type of loneliness (not feeling integrated into social environment whether with people or not - perceived "emotional togetherness") that can be associated with depression.

% DEAD AFTER NINE YEARS		MALE	FEMALE
most social support	IV	21.8	9.7
	III	26.3	16.7
	II	33.0	17.7
least social support	I	39.4	29.4

Table 25 - Social support and mortality in Berkman and Syme (1979) study.

4. Early experiences

Early experiences affect later relationships in two ways - in terms of the child's environment, and through early attachment relationships.

Research using longitudinal studies have attempted to show how past events and experiences influence current relationships in later life. For example, a Dutch survey ("Living Arrangements and Social Networks of Older Adults") found that childhood socioeconomic status (SES) was linked to size of social network in old age. Those with a low SES had smaller social networks, and relied more on kin than individuals whose SES improved over the life course (Broese van Groenou and van Tilburg 2003).

The early childhood relationship (including attachment style) has been found to link to marital stability, and satisfaction with adult relationships (Blieszner 2006).

Patricia Crittenden (1997) has developed John Bowlby's work (eg: 1988) on the importance of early attachments for later relationships. In the dynamic maturational model of attachment, the Adult Attachment Interview (Main et al 1985) is used to categorise the type of adult relationship. But the number of possible categories has been expanded (table 26), and applied to understanding how individuals cope with ageing (Crittenden 2000).

ATTACHMENT TYPE	CHARACTERISTICS
Type A - Insecure: dismissing (8 sub-categories) eg: A4: compulsively complaint eg: A3: compulsively caregiving	Avoid thinking about anxiety by being falsely positive and hiding negative feelings
Type B - secure (5 sub-categories)	
Type C - insecure: preoccupied/enmeshed (8 sub-categories) eg: C4: feigned helplessness	Intense displays of negative emotions to gain help

Table 26 - Crittenden's attachment styles and coping in later life.

5. Parent-child relationship

This relationship is far from static over the lifespan. A Welsh longitudinal study found that help from offspring increased with age while emotional closeness decreased (Wenger 1990).

While the Dutch study mentioned above found that the more help given by a parent to the offspring in the latter's early adulthood, the more help the parent received in later life (ie: reciprocity) (Ikkink et al 1999). Reciprocity is common, and manifests itself in different ways; eg: money from parent to child and direct help from child to parent. The stereotypical picture of old people as giving less than they receive is far from the truth (Blieszner 2006).

But, in a Swedish study, children who perceived themselves as least-favoured in the family provided less help to ageing parents and had a poorer quality of relationship with them (Bedford 1992).

Divorce in later life can also affect the adult children and relationships. Close mother-child relationships were less affected by divorce than less closer ones, while father-child relationships did not show a pattern (Nakonezny et al 2003).

There are situations where parents continue to care for adult children, and this can produce strains depending upon the reason. For example, failure to leave home yet compared to physical or mental health problems. Pillemer and Luscher (2004) proposed the theory of intergenerational ambivalence to explain the strains. Such relationships produce a conflict between the benefits of support and the desire to avoid dependence.

Table 27 lists some of the issues that may cause conflict between ageing parents and adult children.

- Perceived parental unfairness
- Caring for individual with learning or physical disability
- Betrayal
- Too demanding or undependable
- Offering intrusive or unhelpful advice
- Failure to respond in times of need
- Insensitive or critical behaviour

Table 27 - Examples of issues producing conflict between ageing parents and adult children.

6. Friendships

Longitudinal studies have shown that many friendships decline with age, often for practical reasons. Roberto (1997) followed a group of US women for fourteen years. Face-to-face interactions with friends declined due to changes in marital, work, and health status. While, in a sixteen-year Welsh study, friendships declined due to ill, relocation or death (Jerrome and Wenger 1999). There was evidence of replacement of departed friends, however, outside of norms of adult relationships; eg: gender-boundaries crossed, or with new young neighbours.

This study in Bangor, North Wales was based on seventy-one individuals over the age of 80 years first interviewed in 1975 and 1979. Four types of responses to current levels of friendship were found:

- i) "contented" (49 respondents) - have real friends and do not wish for more;
- ii) "dissatisfied" (7) - have real friends, but wish for more;
- iii) "needy" (4) - no real friends and wish for more;
- iv) "resigned" (11) - no real friends and do not wish for more.

Later-life friendships do, however, appear more resilient and tolerant to hurt feelings and infrequent interactions (Blieszner 2006).

In whatever ways friendships change with age, the central themes of best friendships remain constant. Coates (1996) drew out three central themes to best friendships:

- a) Trusting the best friend with secrets;
- b) Having fun with them;
- c) Getting to know yourself better from the friend's reaction.

Each of these themes can be seen in two different age groups of women - a fourteen-year-old in 1957 (Coates 1996) and seventy-nine-year-old Helen (O'Connor 1992) (table 28).

TEENAGER (and Gina)	HELEN (and Vera)
Trust	
sharing diary with best friend	"There's nothing I'd do or be ashamed of that I can't talk to Vera about"
Fun	
"Tied our shoelaces together.. Invented word: Ishish = putting on act" (Feb 3 1957)	Bingo on Tuesday evening, whist drives on Wednesday evening
Self	
"Gina explained our row. It was all my fault really" (Feb 1 1957)	"The relationship with Vera is identity enhancing in the sense that Vera sees her as 'the sort I am'" (O'Connor 1992 p133)

Table 28 - Best friendship themes in two relationships.

8. Loneliness

Loneliness as mentioned above is not simply the absence of friends. Victor et al (2005) noted the complex and subjective nature of loneliness. Importantly, though, there were individuals who were alone in later life, but were not lonely. The issue is whether loneliness is a new experience for an individual as they get older. While some individuals may only be intermittently lonely (eg: at weekends). A balance is required not to sensationalise loneliness in old age and/or present "a mythological past where loneliness was unknown" (Manthorpe 2005-6 p36).

In an extensive British study, Victor et al (2004) found that 2% reported feeling lonely always, and 61% never. Around a quarter were more lonely now than ten years ago, and loneliness in the evening was the most

common specific time.

Analysis of the data from the 995 respondents found risk factors for loneliness; widowhood, mental health problems, poor physical health, poor health expectations (ie: belief that health will get worse), and time alone. The research also found two significant "protective factors" against loneliness: increasing age, and educational qualifications.

Other risk factors for loneliness include living in a poor environment (eg: inner city), and lacking social resources (eg: other people) (Victor et al 2005).

Using Dutch data, De Jong Gierveld (2006) reported the loneliness scores of ten groups of fifty-five years plus adults with at least one child alive. A higher score meant greater loneliness as measured by De Jong Gierveld Loneliness Scale (De Jong Gierveld and Van Tilburg 1999) (0 = not lonely to 11 = ultimately lonely). Widowed men now living alone and divorced women now living alone were most lonely (table 29).

	MALE	FEMALE
Still in first marriage	1.6	1.7
Widowed, now alone	3.6	2.9
Widowed, repartnered after 50	2.2	2.7
Divorced, now alone	4.3	3.8
Divorced, repartnered after 50	2.9	no data

(After De Jong Gierveld 2006)

Table 29 - Loneliness scores based on marital status.

8. Sexual behaviour

This is a taboo subject generally, let alone the experiences of the gay and lesbian elderly (Pollner and Rosenfeld 2000).

It is estimated that 70% of men and 20% of women over 60 years are sexually active, and many others are limited by lack of available partner. Some individuals even report an increased sex drive in later life (Sadock and Sadock 2003). The use of the term "even" here is because of the assumption that sex drive declines with age. West society presents sex as an activity for the younger, and there is often revulsion that older adults may be sexually active.

Society constructs older people as no longer sexually desirable, nor sexually desirous, or sexually incapable (Calasanti and Slevin 2001). Oppenheimer (1997) noted how the topic of sexuality in old age provoked four possible reactions - discreet silence, distaste, upbeat

and open, or making assumptions (eg: heterosexual).

The Duke University Center for the Study of Aging and Human Development longitudinal study (eg: George and Weiler 1981) recorded over half of married participants as sexually active up to seventy-five, and a quarter over that age. Around one-fifth of men in their 80s and 90s reported intercourse frequency of once per month or more.

Self-reported surveys also show a high level of masturbation: 40-70% of men and up to one-third of women in different studies with different age groups (Oppenheimer 1997).

Gibson (1996) listed some of the myths about sexuality in later life:

- a) Semen emission for men hastens death;
- b) Masturbation by older people is harmful;
- c) Women's satisfaction with intercourse declines after the menopause. Of 441 women over 60 years asked "How does sex feel now compared with when you were younger" by Starr and Weiner (1981), 41.0% said "better" and only 19.3% said "worse";
- d) Older women who enjoy sex are nymphomaniacs;
- e) Older men are more likely to be paedophiles. The average age for such offenders is mid-thirties (Gibson 1996);
- f) Older men want young sexual partners. Of eight hundred men over 60, 1.9% specified 20-29 years and 0.4% a teenager as their ideal lover, and 32.2% preferred a woman over sixty (Starr and Weiner 1981).

Cronin (2006) criticised "the presence of heteronormative thinking and practice" in relation to older adults and sexuality. In other words, ignoring the experiences of gay and lesbian older adults.

Cronin interviewed twenty-two self-identified lesbian women aged 45-68 in the UK and the US (half face-to-face, and the others by e-mail). Certain themes emerged:

- Discrimination: "triple whammy" (woman, senior citizen, and lesbian) (Mary, 68 years old);
- Feeling different now: "I do have friends.. who are straight and who accept me totally.. But they don't understand, deep down inside, that there is a difference between us" (Donna, 58 years old) (p118);

- Getting married at a younger age because of social pressures: eleven of the women were divorced or separated, and ten of these had children: "I was trying to 'do what was right' by society's standards, even if they weren't right for me" (Lesley, 54 years old) (p114);
- Feeling different in the past: "To me, flirting with boys wasn't fun; it wasn't natural; it was a waste of time. I felt out of kilter from then on" (Chris, 56 years old talking about her teen years) (p115);
- True self: "As a child, once I realised I was attracted to other girls/women, I didn't actually 'think' about it.. It felt like the 'real me'" (Chris, 56 years old) (p114).

Knocker (2006) reported on the double invisibility of gay older adults with dementia living in residential care: "Given that even conservative estimates would suggest that one in fifteen service users are likely to be lesbian, gay or bisexual, it is alarming how they appear to disappear once they enter into a care setting" (p23).

Crime: Victims and Perpetrators

VICTIMS

Traditionally older people have the highest reported fear of being victims of crime, particularly violence. But the figures on risk of victimization show that the younger age groups (eg: 16-24 years) have the highest risk of robbery, assault, and rape (eg: Mirrlees-Black et al 1998) (table 30).

	BURGLARY	VEHICLE- RELATED THEFT	VIOLENCE MALE	FEMALE
16-24 yrs	15.2	21.0	20.9	8.8
65-74	3.5	7.8	0.2	0.8
75+	4.1	5.5	1.0	0.2
ALL			6.1	3.6

(After Mirrlees-Black et al 1998)

Table 30 - Rates (%) of victimization for different crimes, young versus old age groups, in Britain in 1997 according to British Crime Survey.

British Crime Survey data showed that over 60s had at least one-eighth of the risk of assault as 16-30 year-olds, and less than half the risk of "predatory street crime" (Jacoby 1997). However, women over sixty reported feeling most unsafe in the same surveys.

Table 31 compares more recent official figures for 2002-3 for victims of crime and fear of crime from the British Crime Survey in England and Wales.

	MALE ALL *	OLDER	FEMALE ALL *	OLDER
Concern about (60yrs+):				
Mugging	9	10	19	20
Physical attack	7	6	22	18
Victims (65-74/75yrs+)				
Mugging	1.0	0.2/0.1	0.6	0.4/0.5
All violence	5.3	1.3/0.4	2.9	0.7/0.6

(* = 16yrs and older)

(After Office for National Statistics 2004)

Table 31 - Concern (%) about violence and victims of violence in England and Wales, 2002-3.

The area of sexual assaults on elderly people is a neglected area of study with "some reluctance to accept that it was other than a very occasional occurrence" (Jeary 2005).

Studies of offenders who sexually attacked older women found that there was a high level of violence used (Pollack 1988), and the victim was more often a stranger (Groth 1978) ⁽¹⁷⁾. But Safarik et al (2002), in a US study of sexual homicide of elderly females, questioned the stranger classification. The offender may have done "odd jobs" for the victim or seen them around the neighbourhood.

Safarik et al also questioned the view that the sexual homicide was a burglary gone wrong. The researchers noted that the "removal of property occurred subsequent to the homicide", and involved easily accessible items like cash or jewellery.

In the UK, the most extensive study on sexual assaults on the elderly was undertaken in 2003-4 by the Government and relevant agencies (Jeary 2005). It involved secondary qualitative analysis of fifty-two prison case records (of 54 victims) which had sexually attacked victims sixty years or older. The types of offences were divided into four categories:

- i) Sexual assault and killing (12 victims);
- ii) Rape/attempted rape (20 victims);
- iii) Indecent assault/alleged indecent assault (20 victims);
- iv) Sexual harassment (2 victims); eg: sending anonymous offensive sexually explicit letters.

The majority of the first two categories (2/3) were committed by offenders younger than thirty years old, exclusively upon women (bar one victim), who were strangers, in their own homes. The other one-third, committed by offenders over thirty years old, were more likely to be with a known victim (eg: relative; careworker). Many of the third category of offences took place in the victim's home environment without the knowledge of family or carers.

Once again Jeary found the use of excessive violence leaving the living victims with severe injuries. Some of the documentation available reported the traumatic effect upon the victim, even leading to them moving house:

The day-to-day realities for the victims, however, encompassed being fearful or unable to sleep at night, having nightmares, requiring painkillers as a result of the injuries, suffering from incontinence since the assault, experiencing pain when passing urine because of the injuries sustained,

loss of weight, fear of having been exposed to a sexually transmitted infection, anxieties about leaving the house and thereby losing the enjoyment of social activities such as shopping, fear of men about the age and stature of the attacker, and so on (Jeary 2005 pp335-336).

So it could be that the fear of crime victimization by older adults has some foundation. They are less likely to be sexually attacked than younger age groups, but when it does occur it is more violent.

In terms of the motivation of the offenders, a theme that emerged from the case reports was an inability to perform sexually in "age-appropriate relationships":

Some saw their offence as a means of testing out.. aspects of sexual performance; their failure then often triggered excessive violence towards the elderly woman.. The feelings of sexual inadequacy lead the men to seek out victims who would potentially be least able to resist, to mock, or to report on their sexual performance (Jeary 2005 p337).

While around 20% of offenders had admitted to professionals sexual fantasies about older women before the attacks.

Another theme of the offenders' motivation was a desire for revenge against the victim or women generally. For example, a middle-aged man, who attempted to rape his mother, reported resentment about caring for her at the expense of all other aspects of his life (like relationships).

In 50% of cases, the offender reported childhood abuse, and around 20% had convictions for sexual offences against children as well. The common link for one offender between young girls and elderly women was less likelihood of disclosure: "They won't, or can't, tell" (Jeary 2005 p341).

OFFENDERS

Among the stereotypes of elderly people is the view that they cannot be offenders. The rate of offending is low for the age group, but still there are criminals.

According to Government figures, relative to other age groups, over 60s are a minute feature of offending (less than 1% guilty of all indictable offences in England and Wales compared to over 70% by under 30s) (Jacoby 1997). The most common crime by over 60s were sexual offences followed by fraud and forgery (Jacoby

1997).

The proportion of males over sixty years old in the total prison population in England and Wales was 2.2% in 1999 (Home Office). This has slightly increased in the following years (table 32).

The proportion of imprisoned sexual offenders over sixty was 38.1% of the prison population for that age group in 1999 (Home Office 2000). This figure is now higher (table 33).

	TOTAL PRISON POPULATION		60 YRS & OLDER (N/%)	
	MALE	FEMALE	MALE	FEMALE
2001	51 313	2899	1211 (2.36)	18 (0.62)
2002	53 967	3339	1365 (2.52)	19 (0.57)
2003	55 962	3477	1413 (2.52)	28 (0.81)

(After Office for National Statistics 2005)

Table 32 - Prison population of 60 years and over in England and Wales on 30 June 2001-3.

	NUMBER OF SEXUAL OFFENDERS OVER 60 YRS OLD		% OF ALL SEXUAL OFFENDERS		% OF 60 YRS + PRISON POPULATION	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
2001	686	2	13.5	8.0	56.6	11.1
2002	794	1	15.0	4.34	58.1	5.26
2003	838	2	15.2	7.69	59.3	7.14

(After Office for National Statistics 2005)

Table 33 - Imprisoned sexual offenders over sixty years old in England and Wales on 30 June 2001-3.

Curtice et al (2003) detailed the case of thirty-one male offenders and one female offender (aged between 65-84 - elderly mentally disordered offenders; EMDO) at Fromside Clinic in Bristol between 1988-99. This is a regional secure unit for offenders who are classed as mentally disordered (legally) and thus not sent to prison.

Of the sample, interestingly only 44% had a mental disorder (clinical definition), 19% dementia, 6% depression, 6% chronic paranoid schizophrenia, 3% schizoaffective disorder, 3% organic personal disorder, 3% mild learning disability, and 3% alcoholism.

The most common offences were sexual with minors (56% of sample), and indecent assault was the most commonest of them. Again interestingly, half of them were first time offenders and half recidivists. One theory for the first time child sexual offenders in later life is that the "long-lasting 'Achilles heel'" can no longer be controlled as ageing and/or dementia occurs (Soothill et al 1976). Only two of the first time child sexual offenders had dementia and one of the recidivists.

Curtice et al questioned the presence of eighteen individuals without a diagnosis of mental illness: other studies have noted a "lenient attitude to elderly offenders by the police and criminal justice service".

Cognitive Changes

Traditionally it has been assumed that old age automatically means cognitive decline. This is not the case for healthy older adults. There are many different cognitive abilities, and ageing affects them in different ways. Table 34 summarises the research conclusions about ageing and different aspects of memory (Cohen 1996; Morris 1997), and table 35 does the same thing for other cognitive abilities (Morris 1997; Stuart-Hamilton 2000a).

MEMORY ABILITY	EFFECT OF AGE
Short-term store	small decline in capacity, but no difference in rate of forgetting
Working memory	deficit, but disagreement over exact nature
Long-term memory	free recall declines but not recognition
Verbal LTM	no difference for cued recall
Episodic memory	decline for recent events
Semantic memory	superior to younger adults
Procedural memory	no difference for well learned skills, but learning new skills slower
Explicit memory	some decline
Implicit memory	small decline
Spatial memory	no difference in studies using maps aligned in correct direction
Memory for source of information	declines
Encoding	"patchy" evidence for decline
Retrieval	if declines, due to encoding problems or other weaknesses
Autobiographical	recall of past events at expense of recent events not supported
Prospective memory	some decline, but depends on other factors like anxiety or intelligence
Learning/studying	age effects non-existent for high intelligence adults

Table 34 - Ageing and memory changes.

COGNITIVE ABILITY	EFFECT OF AGE
Divergent thinking/ problem-solving	declines
Sustained attention	limited decline
Selective attention	some differences found, but may be due to cohort effect (Stuart-Hamilton 2000a)
Divided attention	decline on dual task studies if both tasks complex
Word recognition	no difference except on complex experiments; eg: lexical decision task: saying if groups of letters form word; some advantage of ageing for recognition of words in isolation
Story comprehension	slower reaction time, but depends on nature of experiment, and reading ability of participants

Table 35 - Ageing and some cognitive abilities.

MEMORY

The simple idea that memory inevitably declines with age is not accepted now. There are a number of factors involved in memory decline or not in older age.

i) The use of memory

Traditionally research has used easily accessible samples for studies, like older people living in residential care. Such individuals do show a poorer recall of recent events relative to older ones. But when Holland and Rabbitt (1991) used a sample of older people living independently in the community (16 x 70-85 years), they found recall for recent events much better than earlier ones (table 36).

	RESIDENTIAL CARE	INDEPENDENT LIVING
FROM FIRST THIRD OF LIFE	5.2	6.8
FROM CURRENT THIRD	3.4	7.8

(After Holland and Rabbitt 1991)

Table 36 - Mean number of episodic memories generated in ten minutes by two groups of older adults.

ii) Different types of memory

There are different types of memory, and not all show the same changes in later life. For example, Maylor (1994) plotted the ages of "Mastermind" quiz winners. The performance on general knowledge questions improved with age (ie: semantic memory).

iii) Biological changes

Activity in certain parts of the brain associated with memory (eg: hippocampus) reduces with age, but this can be overcome.

What cognitive decline that does occur naturally with age can be slowed down or even reversed based on work with mice led by Fred Gage in California. Generally young active mice grow more neurons in the brain and showed better memory performance than non-active ones. But sedentary old mice who become active also benefit in the same way (Motluk 2005). The question is whether neurogenesis (the growing of new neurons in the old brain) found here is applicable to humans. Whatever the case, physical exercise/active is generally better than none for health in later life.

iv) Memory strategies

Studies have shown that teaching older adults techniques to aid recall can be beneficial. For example, repeated learning improves recall (for all ages).

Kensinger and Schacter (1999) compared recall of forty-five words by 17-25 year-olds and 60-75 year-olds. On the first trial, the younger group recalled more, but both groups showed increased recall on subsequent learning of the same words. However, the younger group recalled more overall.

v) Personal memories

The inevitable decline in memory for older people compared to young adults is not always the case. Anderson et al (2000) used twenty-eight older adults (average age 72 years) from the University of the Third Age, and twenty-eight younger adults (average age 28 years) who worked for the Open University. They were asked to write about two personal memories of their choice - one that was often recalled (high-frequency memory) and the other rarely recalled (low-frequency memory). Two months later all the participants were given a surprise memory test. Table 37 shows that the older adults' recall was

significantly better.

The researchers noted that the frequency of rehearsal of the memory did not affect recall. But they accepted that when "people are asked to repeat information that they have already given they usually assume that the original version was unsatisfactory in some way and may try to rectify this by supplying more details" (Anderson et al 2000 p440). This, of course, would have reduced recall accuracy scores in the experiment.

	OLDER	YOUNGER
MEAN NUMBER OF FACTS (ORIGINALLY)	12.25	10.94
MEAN NUMBER OF FACTS RECALLED	8.34	6.31
PERCENTAGE OF FACTS RECALLED	69.12	57.79

(After Anderson et al 2000)

Table 37 - Recall of facts in Anderson et al (2000) experiment 1.

In a second experiment, Anderson et al (2000) recruited fifteen older adults (average age 72 years) living in the community in Bristol and fifteen mature students (average age 36.5 years) at university in Bristol. Participants were asked to give details of specific personal memories from one, five and ten years ago. An unexpected memory test was given two months later. Again the older participants did better than the younger ones (table 38).

YEARS AGO	1	5	10
OLDER	53.4	68.3	71.1
YOUNGER	34.8	49.1	47.6

(After Anderson et al 2000)

Table 38 - Percentage recalled of memories based on years ago.

Anderson et al (2000) felt that the recall of older adults was more stable because the personal memories were reproductions rather than reconstructions by younger adults. The researchers concluded:

The process of reconstructing memories by activating and combining knowledge structures from a generalised knowledge base and fragments of specific memory.. is demanding in terms of cognitive resources. Given that reconstructive retrieval may be too demanding for the diminished cognitive resources of the older, the shift to a reproductive process can be seen as a compensatory mechanism (Anderson et al 2000 p451).

This may explain the finding that older adults retell the same story word for word for significant memories (Rabbitt 1988).

Issues with Memory Research

Richie (1998) pointed out a problem with many of these experiments. Namely the broad age range of older adults used (eg: 60-100 years): "no competent researcher would refer to 'the young', combining data from 10-50 years" (p97).

Overall, "some older adults lose skills because they bare no longer important in their lives" (Stuart-Hamilton 2000a p84). This has implications for research comparisons between age groups. Thus "if a significant proportion of older adults are using different logical systems, then is such a comparison fair or meaningful?" (p85).

Stuart-Hamilton (2000a) added: "A related problem concerns self-image: Older people often expect to be forgetful, younger people do not. Accordingly, older people may be more sensitive to memory lapses, and so unrealistically downgrade their abilities" (p111).

Also misplacing items may not be a memory lapse but overlooking the item during a search. Thus a problem of misperception not memory (Tenney 1984).

Attempts have been made to find the effects of "pure" ageing. However, there are many confounding variables with comparisons between young and old participants including the degree to which skills used, level of education, level of motivation, relevance of experimental measures to everyday life, and "unwitting ageism" (Stuart-Hamilton 2000a).

INTELLIGENCE

The traditional design of research on ageing and intelligence has been cross-sectional (ie: testing different age groups at one point in time). Using this method in 1953, Schaie found a massive decline in IQ

scores in the older age groups.

But when he studied the same individuals using the longitudinal study - retesting them in 1963 (Schaie and Strother 1968), 1970 (Schaie and Labouvie-Vief 1974), 1977 (Schaie and Hertzog 1983) and 1984 (Schaie 1988) - the individuals showed little decline in their IQ scores (Schaie 1983; 1996). The results with the cross-sectional design are due to the cohort effect. These are differences common to each age group - for example, a thirty year old will be more familiar with IQ tests than a seventy year old.

Table 39 shows an example of the differences in IQ scores between cross-sectional and longitudinal designs.

It is now accepted that intelligence has a number of components which vary with age. Crystallized intelligence (eg: general knowledge) increases with age, and fluid intelligence (eg: speed of information processing) declines (Horn and Cattell 1967). The improvement in crystallized intelligence can be seen as wisdom or "social intelligence".

		CROSS-SECTIONAL DESIGN - different individuals at each age	LONGITUDINAL DESIGN - same individuals at different ages
AGE: YEARS	25	55	55
	39	56	55
	53	54	57
	67	48	57
	88	35	55

(After Wood et al 2002)

Table 39 - Examples of verbal meaning IQ scores using two different research designs.

Stuart-Hamilton (2000b) summarised the current view:

..(T)here is a general decline in intelligence in older adults. This is principally due to fluid rather than crystallized factors (though the latter are, in part, measurement artefacts)..To some extent, decline may be offset by compensation (p21).

WISDOM

Age and wisdom are assumed to go hand in hand. But the question is what is wisdom. Coleman and O'Hanlon (2004) noted the positive aspects of greater insight and awareness, and the negative side of knowledge about the

destructive aspects of human behaviour. Table 40 lists some of the characteristics associated with wisdom.

There is a certain irony to the assumption that all ageing adults are wise because there is "so little utility in the elderly" (Holliday and Chandler 1986).

CHARACTERISTICS	STUDY
- learning from experience, open-minded, knowledgeable	Holliday and Chandler (1986) 150 adults describe "wise person"
- creative for arts and philosophy subjects, but not business; not same as intelligence	Sternberg (1985) university professors
- greater awareness and insight; empathy with others; awareness of conflict and ambiguity; ability to regulate emotions; openness to experience; find alternative solutions to problems	Coleman and O'Hanlon (2004) textbook summary
- types including cognitive, practical-experimental, interpersonal, ethical-moral, spiritual-mystical	Randall and Kenyon (2001) biographical interviews
- Knowledge about different aspects of life and world	Baltes and Smith (1990) model

Table 40 - Characteristics of wisdom according to different studies.

Life Events and Adjustment to Ageing

Life events are studied generally in three ways (Davies 1996):

i) A group are studied after the event (index group) for a certain period and compared to a group not experiencing the event. This is similar to a natural experiment or static group comparison pre-experiment (Brewer 2002b), and there are no pre-event measurements;

ii) Case control method - a group after the event are interviewed in retrospect about their experiences. This has all the weaknesses of any study that is based upon the participants' memory;

iii) Community survey - a random sample are studied to see how many and how often the events occur. These can be longitudinal studies which follow the group for a certain period of time. There is no guarantee that anyone in the sample may experience the life event being studied.

Two key factors are involved in the negative effect of life events upon an individual:

a) Nature of the life event - Krause (1994) has argued that life events that threaten the individual's social identity (eg: spouse, parent) cause more negative effects;

b) Social support - Consistently social support has been shown to reduce the negative aspects of stress and life events in all age groups. Social support from friends was most beneficial where available followed by family, and paid support last (Davies 1996).

Coping with stress is a key aspect of change and life events. Older adults seem to adapt their coping strategies. The Bonn longitudinal study (Rott and Thomae 1991) investigated different areas of stress for 222 Germans over 55 years old during twenty years.

"Asking for help" was the major strategy that increased, but not for income problems. While "depressive reactions" declined particularly for women and health problems.

RETIREMENT

Retirement from paid employment is a key life event for the older age group, and adjustment to the new status of retired can dominate the 60s.

Whether the experience of retirement is stressful or not, and the degree of stress depends upon different factors (table 41) (Bosse et al 1996).

FACTOR	INCREASES STRESS	REDUCES STRESS
Circumstances of retirement	early retirement; unexpected/ involuntary	voluntary
Social economic status (SES)	higher SES for men; loss of income particularly for women	
Occupation	no pattern	
Health	not retirement on health grounds	
Hassles	high level eg: marital, financial	
Life events	more negative life events in lifetime for men and previous year to retirement	more negative life events in lifetime for women
Social support		more; quality of support more important than quantity
Work saliency ie: miss job satisfaction	men high job satisfaction	
Prior work stress	low stress job	high stress job
Personality	no relationship with extraversion (E) or neuroticism (N)	

Table 41 - Factors influencing the nature of stress and retirement.

The experience of retirement can vary with social class. Andersson and Oberg (2006), using Swedish data, proposed three models for health differences after retirement between white-collar and blue-collar workers (table 42);

- i) "Catch-up" - an evening out of health differences between the groups;
- ii) "Business as usual" - differences between the groups remain the same;
- iii) "Delayed effects" - differences between the groups expand after retirement.

WHITE-COLLAR

BLUE-COLLAR

Year since retirement:	1-2	12+	1-2	12+
"Catch-up"				
- approx % reporting long-term illness	55	75	75	85
"Business as usual"				
- approx % reporting health problems	25	44	38	58
"Delayed effects"				
- approx % reporting physical disability	8	28	8	38

(After Andersson and Oberg 2006)

Table 42 - Health after retirement for white-collar and blue-collar workers in Sweden.

HEALTH

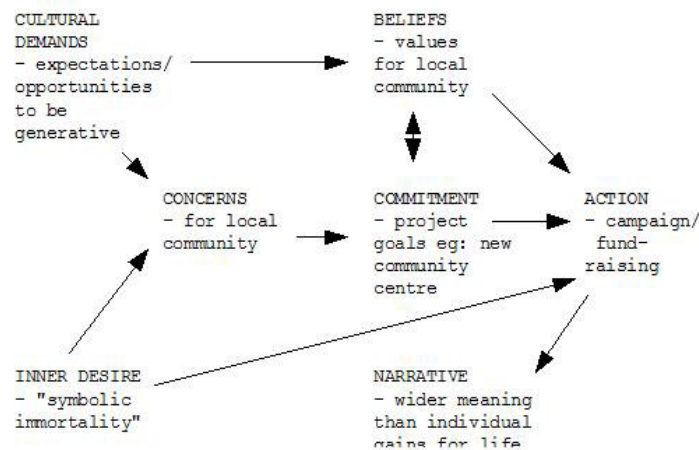
McMurdo (2000) pointed out that old age does not cause disease, though older people have poorer health than younger ones. Positive health and lifestyle factors can postpone disability, and problems that arise from disuse (eg: muscle strength), as well as increase lifespan:

A healthy old age depends heavily on luck and genetic and other factors that are not amenable to intervention. Nevertheless, lifestyle factors in later life are crucial influences on healthspan and disability and are potentially modifiable (McMurdo 2000 p1151).

GENERATIVITY

Erikson described the seventh stage of his theory as "generativity versus stagnation" for later middle age. The positive stage of the stage is generativity seen as teaching, guiding and supporting future generations (eg: parenting, mentoring) or building and creating for the benefit of others. Put another way, it is about leaving something lasting after the individual is gone - "symbolic immortality" (Coleman and O'Hanlon 2004).

McAdams and de St Aubin (1992) developed the idea of generativity in the Loyola Generativity Scale (LGS), and produced a detailed model. Figure 3 shows the model as applied to an older adult helping to improve the local community.



(After Coleman and O'Hanlon 2004)

Figure 3 - Model of generativity and helping the local community.

As with many of the theories on ageing, it is based on research in the US and is very applicable in individualistic societies. But what about other societies and cultures around the world?

Research has shown that generative concerns are linked to good psychological well-being in later life. Keyes and Ryff (1998) found this in their US study of 3000 non-institutionalised English-speaking adults aged from twenty-five to seventy-four years. Generativity was measured by the LGS, hypothetical scenarios, and a thirty-minute telephone interview. It may be that generativity leads directly to positive psychological well-being, or that generativity produces feelings of high self-esteem, integration and satisfaction, which in turn lead to positive psychological well-being. Put simply, older adults who are doing something active and meaningful with their lives feel better psychologically.

REMINISCENCE AND LIFE REVIEW (18)

This is more than just recalling past events, rather it is an attempt to place meaning upon life as individuals realise their lives are coming to an end. It is viewed as a normal part of ageing now due to Robert Butler (Butler 1963), and Erikson in his later writings (eg: 1978).

The question is whether recalling personal memories does actually produce a greater understanding of the whole of life. For example, Wink and Schiff (2002) interviewed, at length, 172 participants in their 60s and 70s from Berkeley, California. Two independent judges studied the transcripts and rated (on a five-point scale) for evidence of new self-understanding from recalled memories. Only 22% of the sample showed this, 58% no evidence, and for the other 20% it was unclear.

Reminiscence and life reviews can also have general benefits for psychological well-being. Fielden (1990) compared two sheltered housing complexes in England receiving weekly sessions either reminiscence or present-centred. The former group showed improvement in well-being over the nine weeks of the study.

RELOCATION

Many older adults face the experience of relocating from their homes to residential care, for example. Research in the 1970s tended to see the experience as all negative. More recent studies take into account pre-move characteristics (eg: mental health), degree of preparation, and amount of choice involved (Davies 1996).

Factors that facilitate a good adjust include familiarising new residents to environment (eg: landmarks), and emphasising opportunities for choice and control. But a loss of "sense of place" and sudden unexpected moves are associated with negative consequences like depression and lower life satisfaction (Davies 1996).

The experience of the relocation to a residential home will be affected by how the individual sees their environment (ie: the meaning attached to their house). Kellaher et al (2004) undertook fifty-four detailed interviews in the UK. One straightforward issue related to moving was the loss of space. Moving from a house with many rooms to usually the single bedroom/flat of residential accommodation.

The family home with many bedrooms was not necessarily all being used, but psychologically the extra bedrooms were being used; eg: still seen as children's bedrooms or used for occasional guests. Moving to a residential home meant a loss at this psychological level as well.

The practicality of less space also often meant leaving large items of furniture, but those items had associations and memories. While space to display objects represented the self to the self (ie: reinforced aspects of the person), the self to others (eg: achievements),

and others to the self (eg: pictures of grandchildren) (Kellaher et al 2004).

From a different point of view on relocation, the experiences of ageing for migrants is discussed in King et al (2000), O'Reilly (2000), Phillipson and Ahmed (2006) ("new urban underclass"), Torres (2006) (Iranian immigrants in Sweden), and Warnes (2006).

BEREAVEMENT

"In contrast with previous generations, older people in the late twentieth century experience bereavement mainly in their old age" (McKiernan 1996 p159).

One question being asked by researchers is whether grief is different in later life to earlier experiences. Evidence to suggest that an affirmative here comes from studies of widows of different ages. Younger widows have higher post-bereavement mortality and greater incidence of mental illness. But the research is confounded by the unexpectedness of early widowhood (McKiernan 1996).

The experience of bereavement, and whether there is a detrimental effect upon physical and mental health, depends on groups of factors (McKiernan 1996):

i) Relationship factors

a) Type of relationship - loss of an adult child produces greater intensity of grief, even than loss of spouse;

b) Quality of relationship - more "realistic" appraisal of the relationship can be helpful in recovering from the grief;

ii) Type of death

a) Extent of forewarning - older adults only show small benefits with forewarning of death. The effect is strongest for younger adults;

b) Type of illness - grieving can be difficult in cases of Alzheimer's disease where the individuals change drastically. Any relief at the death can be tempered with guilt and self-blame;

c) Suicide - the bereaved by suicide showed more psychological problems in both the short-term and long-term compared to the bereaved by natural causes;

iii) Characteristics of bereaved

a) Self-esteem - low self-esteem may make bereavement worse;

b) Competence in managing the tasks of daily living - bereaved spouses who shared various life tasks were to be less depressed;

c) Previous experience of loss - previous bereavement in childhood produces increased vulnerability to depression, while previous bereavement in adulthood can prepare the individual, except for many bereavements leading to "bereavement overload";

d) Gender - research has shown some gender differences, but it is not clear what they are; eg: men more likely to remarry;

e) Religious beliefs - there are benefits to having such beliefs (as well as the social support of a church, temple, mosque etc);

iv) Contextual factors

a) Income and education - no effect upon bereavement;

b) Social support - generally helpful, particularly at the beginning of the bereavement process;

c) Cultural factors - cultural expectations on the widow can be important; eg: never to remarry; to remain in mourning for a set period.

Effects of Widowhood

Mental health problems can be common in widowhood, of which some cases are only short-lived. Onrust and Cuijpers (2006) performed a meta-analysis⁽¹⁹⁾ of eleven studies with 3481 widowed individuals and 4685 non-widowed controls. In the first year of bereavement, 21.9% of the widows has major depressive disorder and 11.8% post-traumatic stress disorder. The risk of a mood or anxiety disorder was between four and nearly ten times greater than control participants.

There is some dispute over whether there are gender differences on the negative health effects of spousal bereavement. Fry (2001), for example, interviewed 101 widows and 87 widowers aged 65-87 who were bereaved in

the last two years. The research was looking for "existential" factors that predicted good health after bereavement, or put another way, not a health decline.

For widows, five variables were important for post-bereavement well-being: "spiritual beliefs and practices", "comfort from religion", "personal meaning", "optimism", and "importance of religion". But with widowers, only "personal meaning", "optimism", and "importance of religion" were significant. For both groups, there were no significant benefits from "access to religious support" or "sense of inner peace".

Aartsen et al (2005) used data from the Longitudinal Ageing Study Amsterdam (LASA) to show that memory performance is affected by widowhood. The study involved 474 married women and 690 married men in Holland recruited in 1992. By 1998 135 (28%) women and 69 (10%) men were widowed.

Memory was tested with fifteen words read out and immediately recalled at baseline and six years later. Each participant did four trials of the memory test and an average score was calculated (table 43).

	NOT WIDOWED	WIDOWED
Baseline score	6.1	5.9
Six years later	6.0	5.4 *

(* = significant difference)

(After Aartsen et al 2005)

Table 43 - Mean scores out of fifteen on memory test for widowed and non-widowed Dutch older adults.

Footnotes

1. The "oldest old" (people over 95 years) tend to be relatively the most healthiest (ie: more than many younger elderly). Individuals who live this long have few health problems, and often better cognitive ability (especially for men) (Perls 1995).

2. The Berlin Aging Study (BASE) (Baltes and Mayer 1999) started in 1989 with 516 participants divided into six age groups: 70-74 (born 1915-22), 75-79 (born 1910-17), 80-84 (born 1905-13), 85-89 (born 1900-08), 90-94 (born 1896-1902), and 95-105 (born 1883-97). The equal numbers of men and women were followed-up at 2, 4, 6 and 8 years later (eg: Smith et al 2002).

3. Multiple deprivations were:

- Exclusion from material resources; ie: poverty;
- Exclusion from social relationships; eg: social isolation;
- Exclusion from civic activities; eg: never attend community events;
- Service exclusion; eg: not use local services;
- Neighbourhood exclusion; eg: feel negative about local area.

4. Life satisfaction was measured by the 13-item Life Satisfaction Index-Z (Wood et al 1969). There are five response options to items like "As I grow older, things seem better than I thought they would be", which gives a total score of sixty-five (high life satisfaction).

5. Table 44 breaks down the results for the most significant and not significant factors.

	FEMALE	MALE
SIGNIFICANT AT p=0.001		
Quality of social network *	0.45	0.35
Perceived control of life **		
PADL	0.26	0.32
IADL	0.32	0.27
Locus of Control Scale	0.23	0.34
Good perceived health:		
Self-rated health complaints	-0.27	ns
Number of diagnoses from medical records	-0.21	ns
Depressive symptoms ***	-0.42	less sig
Widowhood	ns	-0.25
Social support	0.23	ns
NOT SIGNIFICANT		
	education,	
	social	medications taken,
	economic	frequency of
	status	social contacts
* Measured by four questions; eg: "Do you feel you are part of a set of friends?" (score 0-12)		
** Measured by Personal Activities of Daily Living (PADL) (ability to look after self eg: dressing) 14 items and score 0-43; Instrumental Activities of Daily Living (IADL) (ability to do practical activities eg housework) 7 items and score 0-21; Locus of Control Scale (Rotter 1966) 12 items and score 12-60		
*** Measured by Centre for Epidemiological Studies Depression Scale (CES-D) (Redloff 1977) 20 items and score 0-60; 16+ = major depression; mean for men in sample 8.9 and for women 7.1		
(After Berg et al 2006)		

Table 44 - Correlations between factors and Life Satisfaction Index-Z score.

6. Cumming and Henry's theory was based on a large-scale study in Kansas city in the 1950s. David Gutmann, who was part of that research team, re-interviewed some of the individuals much later. He described the idea of retired individuals as "emeritus parents". Women became more involved in the extended family, and men disengaged from work values to focus on deeper values (eg: "Grey Panthers" campaign group in USA) (Gutmann 1997). This version of the disengagement theory is more about replacement.

7. A internet search (<http://www.yahoo.co.uk> accessed 15/8/06) for "demographic timebomb" (a commonly used term in relation to the increasing older population) produced 4190 hits. The first hit was "Age of the Timebomb" in "The Scotsman" 16/11/01.

However, there were 47 500 hits for "positive ageing". I am not sure that this tells us anything really.

8. Random telephone samples in North America reported elder abuse around 4%, with physical abuse as the most common (Fisk 1997).

9. "Individuality" includes feelings of independence and achievement; eg: "I am proud.. I have achieved a lot" (male, 54 years old), and "When I think about myself.. I am rather satisfied" (male, 78 years old) (Westerhof and Bode 2006).

"Relatedness" includes social competency, and quality of relationships; eg: "I am proud that.. the children are doing well" (female, 82 years old), and "I am proud that.. I have seven children" (male, 78 years old) (Westerhof and Bode 2006).

10. Modernity is seen as a period of stability characterised by "faith in progress, in science to solve problems, in the rational; and in the perfection of humanity" (Brewer 2001). While post-modernity is a period of uncertainty and fluidity. Polkinghorne (1992) listed the themes of "post-modern thought" as foundationlessness, fragmentariness, constructivism, and neopragmatism.

11. Cooper (1997) reported that 69% of adults with learning disabilities aged over 65 had a mental disorder. The most common being depression and dementia.

12. Adults who have long-life psychiatric illness, when reaching senescence are classed as "graduates" (Campbell 1997).

13. Brewer (2003) questioned minor depressive disorders as "the desire to increase the categories of mental disorders, and to limit what is normal to an even smaller area" (p14).

There is also controversy over the use of ECT as a treatment for depression in the elderly. There are claims that it is more effective with older adults than the general population (Tew et al 1999). Brewer (2005) was critical of the use of ECT generally, and whether it is effective. The use with depressed adults with dementia is even more of a concern.

Baldwin et al (2002), writing as psychiatrists, summed up the "official attitude": "ECT can be given safely to patients with dementia and is effective, albeit

with a high rate of transient delirium.." (p82).

Brewer (2002a) argued that unpleasant side effects for the patients of biomedical treatments are seen as a normal, yet unfortunate, part of psychiatry, however extreme the side effects.

14. There are 15 items on the Suicide Intention Scale each with three response choices. The items are divided into:

- Objective circumstances related to suicide attempt (8 items)

- eg: Precautions against discovery/intervention

- 0 = No precautions

- 1 = Passive precautions; eg: avoiding others but doing nothing to prevent their intervention, alone in room with unlocked door

- 2 = Active precautions; eg: locked door

- Self-report (7 items)

- eg: Degree of premeditation

- 0 = None, impulsive

- 1 = Contemplated for three hours or less before attempt

- 2 = Contemplated for more than three hours before attempt

15. While the theory of relational competence (Hansson and Carpenter 1994) explained how individuals focus on familiar people in relation to developmental needs.

16. Clarke and Roberts (2004) produced a British study on the meaning of grandparenthood.

17. Russell (1982) argued, based on victim surveys, that only a small number of sexual attacks generally are committed by complete strangers (eg: less than 20%). Canter and Heritage's (1990) analysis of sixty-six UK sexual assaults found that excessive violence was only used by a certain type of attacker ("victim as vehicle" type).

18. There are different types and approaches to reminiscence and life reviews; eg: Bluck and Habermas (2000); Coleman (1986); Webster (2002); Wong and Watt (1991).

19. Some details from the meta-analysis (Onrust and Cuijpers 2006):

- Studies (11) - USA (9), Netherlands (1), Australia (1).
- Mental disorders - 5 studies on major depressive disorder, two post-traumatic stress disorder, three studies on both these, 1 on panic disorder and generalised anxiety disorder.
- Age range - 45.8 to 77 yrs; six studies had mean age below 65 years old and 5 studies above.
- Number of participants - varied from 57 to 5449; one study all female and one all male, and the rest had majority female.
- Prevalence rates - major depressive disorder 9-31%, post-traumatic stress disorder 6-25%, panic disorder 10%, and generalised anxiety disorder 31%.

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APPENDIX 1

Joan Erikson's 9th Stage ¹

The focus in developmental psychology over the years has remained largely on childhood and adolescence, this focus being reflected in theory with many tending to view development as complete by the teenage years. In his book "Childhood and Society" (first published 1950, revised 1963) Erik Erikson took development a step further by adopting a lifespan perspective that assumes the importance of the whole life for continual development of identity, from birth to death.

His "eight ages of man" are well-known. What is less well-known, however, is his work on the ninth stage which arose as his wife, Joan, and himself reached their nineties. They reflected on their experiences of this older age and how it was not fully explained by his eighth stage.

As Joan describes:

Old age in one's eighties and nineties brings with it new demands, re-evaluations, and daily difficulties. These concerns can only be adequately discussed, and confronted, by designating a new ninth stage to clarify the challenges (Erikson 1997 p105).

Erik didn't ever publish his ninth stage but Joan later completed his work after his death in 1994. In her book, "The Life Cycle Completed: A Review", the ninth stage is presented. This ninth stage takes into account the probable growing frailty and loss of ability in oldest age. Here the individual returns to each of the previous stages with the wisdom of a life lived. "Successful" passage through the ninth stage leads to gerotranscendence, as discussed below.

In the ninth stage Erikson (1997) felt that the dystonic, or negative, side of the dilemmas faced at each of the eight stages may predominate and hence they are presented before the syntonic (positive) elements in each case for emphasis.

¹ This article first appeared in Psychology Teachers Update no.7, September 2004.

Basic Mistrust vs Trust: Hope

Here the older individual begins to mistrust their own abilities due to their increasing frailty. However, hope, emerging with each new day, will still remain.

Shame and Doubt vs Autonomy: Will

Once again doubt returns with respect to the individual's own capabilities. However, Erikson talks of the "rebellious" side of autonomy in old age.

Guilt vs Initiative: Purpose

Here the drive once seen in initiative is reduced and the individual's waning energy is focused on maintaining daily activities.

Inferiority vs Industry: Competence

Again industry is seen as only a memory, replaced by a slowed pace where the individual accepts their shortcomings.

Identity Confusion vs Identity: Fidelity

The difficulties of role confusion re-emerge for the older person. They wonder about their role in this new era of ageing.

Isolation vs Intimacy: Love

Diminishing ability may hinder the individual's usual ways of relating to others. There may be difficulties in knowing how to relate, linked with role confusion, alongside the decreasing number of people with which they interact.

Stagnation vs Generativity: Care

With loss of energy in older age generativity is no longer an issue. This can be seen as liberating the person from being a provider of care. However, this in turn can lead to stagnation.

Despair and Disgust vs Integrity: Wisdom

There are challenges to wisdom in older age due to failing abilities, such as eyesight and hearing, required to "listen, hear and remember".

Despair continues into the ninth stage but takes on a different form. In the eighth stage despair is about reflecting on one's life and how it may have been lived differently. In the ninth stage loss of own ability may take centre stage. If hope from the first stage remains then life will remain worthwhile.

Erikson (1997) felt that if individuals in their ninth stage could come to terms with each of the dystonic aspects of the previous stages then they may move towards gerotranscendence, a stage where the individual chooses to withdraw and their focus shifts from the individual to a wider cosmic understanding and sense of peace towards their inevitable death.

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APPENDIX 2

Quality of Life for People with Learning Disabilities with a Diagnosis of Dementia

INTRODUCTION

In the ten years following a comprehensive review of ageing in people with learning disabilities supported by the Joseph Rowntree Foundation which revealed only thirteen studies (Hogg et al 1988), there has been an explosion of interest and some two hundred papers and books have been cited in recent reviews.

The extensive GOLD (Growing Older with Learning Disability) project led by the Foundation for People with Learning Disabilities is a major UK initiative. This included several extensive reviews and reports that link with many of the worldwide initiatives investigating this population. The major review that has influenced this study is the "Older People with Learning Disabilities: A Review of the Literature on Residential Services and Family Caregiving" (Hogg and Lambe 1998a).

Life expectancy in some western countries has not only doubled during the 20th century, those surviving to sixty-five years do so in better health than in the past, due to improved medical and social factors. This increased longevity has also benefited those with learning disabilities, and half of this population now enjoys better health and a longer lifespan (Hogg et al 1988).

Research indicates that the exceptions are those people with profound and multiple learning disabilities, and those with Down's Syndrome (Eyman et al 1991), due to chronic medical conditions such as heart and thyroid function and premature ageing.

Although the mean life expectancy of people with Down's Syndrome is still less than that of the general population, it has increased from ten years in the early 1900s to nearly fifty years in the 1980s, and over 20% or more of people with the syndrome may be over 55 at any one time (Penrose 1949; Malone 1988).

People with learning disabilities are far from a homogeneous group. Despite methodological issues surrounding the aetiology of learning disabilities, there is certainty that Down's Syndrome is one of the single most common causes of intellectual disability (Janicki and Dalton 1999a), possibly as high as 1:700 live births, related to maternal age (Emerson and Hatton 2001), and this is particularly relevant with regard to longevity and ageing.

The impact of increasing prevalence of the whole learning disability population in the over-60s will in the next two decades be very gradual (Hogg and Lambe 1998b).

Literature, research and policy acknowledge that increasing longevity has led to the emergence of both universal ageing processes and specific age related illnesses within the learning disability population. This is acknowledged by the Department of Health in "A Strategy for People with Learning Disabilities" (1995) and the in the "Health of the Nation" report (1992), more specifically in the third key area of mental illness.

Turner and Moss (1996) reported that the pattern of such illness among people with learning disabilities differs somewhat from the general population. An area of concern with respect to ageing generally is the development of Alzheimer dementia and vascular dementia.

DEMENTIA

Dementia is a progressive mental deterioration in adults that is coupled with personality changes based on clear neuropathological changes in the brain. The most common cause is Alzheimer's disease.

Onset and progression of this disease can be characterised into stages. These chart the early, middle and late stages of the disease and are described widely in the literature (Janicki and Dalton 1999b).

The early stage, lasting between one and five years, is characterised by "onset features" of short-term memory loss, language disruption, and vocational dysfunction. The middle stage shows more pronounced losses and marked decline in language, comprehension, disorientation, confusion, and further short-term memory loss, and can last between five to fifteen years.

The late stage shows complete loss of function and basic skills, both long and short-term memory loss, loss of balance and ambulation (Janicki and dalton 1999b).

With regard to observable behavioural changes, the four As encapsulated these as amnesia, apraxia, aphasia, and agnosia ⁽¹⁾, and characterise the losses as the disease processes. These features present as progressive diminished capacity for self directed activity, personality changes and a loss of behavioural control (Moss and Patel 1997).

For people with learning disabilities without Down's Syndrome, dementia will typically occur in the later years of life with progression similar to the general population (Foundation for People with Learning Disabilities 2001). Progression is markedly compressed

for people with Down's Syndrome, where estimated time of onset to death is nine years, and further complicated by the earlier onset (Visser et al 1997). It is generally accepted that people born with Down's Syndrome develop the neuropathological features of Alzheimer's disease up to forty years earlier than the general population (including those with other learning disabilities), and that the rate of dementia increases with increasing age (Visser et al 1997).

However, not all of those with Down's Syndrome or those ageing in the learning disability population as a whole will develop the clinical features listed above, but for those that do, major burdens will be placed upon carers and services.

Methodological issues surround the studies of prevalence of dementia related illness within the learning disability population as a whole, and wide ranges of figures are posed, from 22% of older people (16% of people aged 65-74, 24% aged 75-84, and 70% over 85), and 6% for over 40s rising to 12% of 80 years and above (Janicki and Dalton 2000). However, similar prevalence to the wider population; ie: 5% of those over 65 years and 20% of those over 80 years was reported in government figures (DoH 1992).

In any given population of older people with learning disabilities the majority with dementia will not have Down's Syndrome, and will tend to be well advanced in years. These varying figures may be attributed to difficulties in detecting the disease and making accurate diagnosis. There is some research consensus regarding these difficulties, which include difficulties of self-reporting, differential diagnosis (of, for example, thyroid disorders, bereavement and depression), low expectations for functioning and loss of abilities being attributed to learning disability (Hogg and Lambe 1998b).

Diagnosis is made by a process of elimination, including the use of extensive psychometric tests, instruments under development for the purpose, and where there is considerable doubt, medical, radiological and neurological studies (Burt and Aylward 1999).

QUALITY OF LIFE

Quality of life remains a "contentious and ill-defined concept" (Emerson and Hatton 1998) that has increasingly become a challenging measure within service evaluation and research (Felce 2000). It is understood as a construct comprising of complex, multifaceted

variables, reflecting crucial and differing life domains (Felce 1997) over which there is some research consensus (Felce 2000).

There is limited research pertaining to people with learning disabilities, and only minor amounts available for older people with learning disabilities. In considering that "They are not older people first, as the rhetoric of some service providers would have us believe, but people with learning disabilities first, who happen to be getting older" (Hogg and Lambe 1997), the disease and emerging and progressive symptoms can be assumed to profoundly impact upon quality of life of affected individuals (eg: Koenig 1995).

Felce (2000) produced the following framework for measuring quality of life:

i) Physical well-being - health and mobility are certainly compromised by the progression and later stages of the disease, and the potential for personal safety compromise is also apparent as a result of the disease;

ii) Social well-being - this encompasses two areas. The first is the quality and breadth of interpersonal relationships, including intimacy and reciprocal affection within household life, with family and relatives, and with friends and acquaintances.

The disadvantaged friendship patterns experienced by the learning disability population as a whole is echoed in this group, in that they comprise of peers and staff (Hogg and Lambe 1998b) and indicate some level of compromise on part of the second dimension of community involvement or social inclusion - the level of acceptance or support given by the community. This is in spite of research evidence suggesting that friendships contribute most to well-being (Antonucci 1990; Peters and Kaiser 1985).

The other part, community inclusion, can be considered alongside wealth and income from (iii) and constructive activity from (iv);

iii) Material well-being - including wealth, income, ownership, transport, and tenure;

iv) Productive well-being - this encompasses the person's ability to use their time constructively according to their own tenets, expressed through pursuits in different arenas, such as home, work, leisure, and education.

Whilst employment in the UK of people with learning disabilities is limited, those employed over 60 is more rare (Hogg and Lambe 1998b), and retirement, even from day services, was considered to be difficult and

unacceptable (Ashman et al 1995).

One other area here is personal development - the acquisition of skills, personal competence or independence. Again, symptom progression indicates that the ability to learn new skills is lost. However, there is some research in the second and third areas pertaining to independence and self-determination (autonomy, choices and control), where older adults in residential services given increased opportunity for choice displayed enhanced daily living skills and improved independence;

v) Emotional well-being - this covers happiness, freedom from stress, mental state, self-esteem, spirituality or religious beliefs, sexuality and contentment, and again is absent from research for all learning disability populations (Felce 2000);

vi) Civic well-being - covers privacy, protection under the law, voting, state of the nation, and civic responsibilities. It is also absent from general learning disability research (Felce 2000).

PRIMARY RESEARCH

A small-scale study (2) was undertaken to assess the quality of life of older adults with learning disabilities. Due to the time-limited nature of the research, a convenience sample of known services and service users from each of the following groups were invited to take part.

Group A comprised of residential service users with learning disabilities and no diagnosis of dementia as an age associated disease. Group B comprised of residential service users with Down's Syndrome and over forty years of age, and those with learning disabilities over sixty-five years with a clinical dementia diagnosis.

Due to difficulties in recruiting and retaining participants for ethical reasons, the actual sample size was sixteen for Group A and fourteen for Group B. They were all resident in residential facilities of between three and ten in capacity.

All participants in Group A were under fifty years, ranging from 32-47 years. For Group B, participants ranged from six aged less than 55 years, four between 55 and 60, three between 65 and 74, and one between 74-85 years. Gender also varied. Group A contained four males and twelve females. Group B contained four males and ten females.

The user groups were compared and matched according to a baseline assessment of Shortened Adaptive Behaviour

Scale (SABS) ⁽³⁾ factor scores (Hatton et al 2001) administered alongside the quality of life measure. Adaptive behaviour is the quality of everyday performance in coping with environmental demands.

The quality of life measure used was the British Institute of Learning Disabilities (BILD) Life Experience Checklist (Ager 1998) ⁽⁴⁾. There are four modes of administration and the most appropriate for this study was the informant rating with an informant who knows the individual well. Following consent, visits to services were arranged to complete the measures which were all taken at one time only.

Table A2.1 shows a summary of the quality of life measures for the two groups studied. Only one sub-section, "opportunities", showed a significant difference ($p = 0.014$). There was no overall difference in the quality of life between the two groups.

There are a number of questions this study sought to answer. In particular, do those with a diagnosis of dementia, experiencing these symptoms enjoy the same quality of life as those who do not, in spite of matched adaptive behaviour and comparable quality of care? The small-scale nature of the study, and the lack of significant differences made answering such questions difficult.

GROUP	N	QUALITY OF LIFE MEASURES					
		GLOBAL	1	2	3	4	5
LEARNING DISABILITY ONLY	16	28.0	7.50	4.50	3.00	5.50	7.00
LEARNING DISABILITY AND DEMENTIA	14	28.5	8.00	5.00	5.00	5.00	5.00

Quality of Life sub-sections: 1 = home; 2 = leisure; 3 = relationships; 4 = freedom; 5 = opportunities

Table A2.1 - Median quality of life global and sub-section scores.

FOOTNOTES

1. Apraxia "is the inability to perform purposeful learned motor acts" despite understanding what is required (Reed 1991). Aphasia is the problem with finding the right words. Agnosia is the inability to recognise familiar objects.

2. This study was undertaken in 2003 as part of the MSc in Analysis and Intervention with Adults with Learning Disabilities course at the Tizard Centre, University of Kent. This is only part of the research which also studied the quality of care of the participants.

3. American Association of Mental Retardation (AAMR) Adaptive Behaviour Scale (Nihiri et al 1993a;b), first designed in 1969, has 73 items divided into ten domains "designed to evaluate coping skills considered important to personal independence and responsibility in daily living" (Nihiri et al 1993b pp2-3).

4. Developed upon principles of normalization (Wolfensberger 1983), the BILD Life Experience Checklist attempts to gauge the extent to which any individual, regardless of their competence, enjoys experiences common to many others of the population.

It encompasses a broad range of life experiences arranged around five central themes: home, leisure, relationships, freedom, and opportunities. The measure yields two scores - a global measure and a profile of each of the central themes showing the extent of experiences, normed against general populations and service receiving populations. The higher the score, the greater the quality of life, according to the number of normally perceived experiences the individual enjoys.

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